OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY

Comprehensive Quality Review Report

Charles H. Hickey Jr. School

June 5, 2008

OFFICE OF QUALITY ASSURANCE & ACCOUNTABILITY
Quality Review Report

Charles H. Hickey Jr. School

Evaluation Dates: May 13-15, 2008

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EXECUTIVE SUMMARY

A quality improvement assessment and evaluation of the Charles H. Hickey Jr. School was conducted May 13-15, 2008 by DJS personnel who are subject-matter experts in the areas reviewed. The areas that were evaluated have been identified as those having the most impact on the overall safety and security of youth and staff. The evaluation was based on information gathered from multiple data sources such as staff interviews, youth interviews, document review and observations of facility operations, activities and conditions.

The following Rating Scale was used:

Quality Improvement Rating Scale

Superior Performance	Strong evidence that all areas of practice consistently exceed the standard across the facility/programs; innovative facility-wide approach is incorporated sufficiently so that it has become routine, accepted practice.
Performance	Performance measure is consistently met across the facility/program; any gaps are temporary and/or isolated and minor; documentation is organized and readily available.
Partial Performance	Expected level of performance is observed but not facility-wide or on a consistent basis; implementation is approaching routine levels but frequently gaps remain; facility had difficulty producing documentation in some areas.
Non-performance	Little or no evidence of adequate implementation of performance measure; the required activity or standard is not performed at all or there are frequent and significant exceptions to adequate practice; documentation could not be produced to substantiate practice.

A total of **44 standards** were evaluated with the following results:*

Rating	# within rating	% of total in rating
Superior Performance	2	4.5%
Performance	27	61%
Partial Performance	13	30%
Non-Performance	2	4.5%

- **The DJS Quality Improvement Performance Ratings are aligned with best practices and optimal standards of care. Therefore, while the facility practice may be in full compliance with minimum constitutional standards, the facility may still receive partial or non performance ratings as a result of QI reviews.**

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Charles H. Hickey Jr. School

Executive Summary of Results

Superior Performance	Performance	Partial Performance	Non Performance
Parent, Guardian & Surrogate Involvement	Incident Reporting	Contraband & Room Searches	Control of Keys, Tools & Environmental Weapons
Section 504 Plans	Senior Management Review	Seclusion	Post Orders
	De-Escalation & Restraint	Perimeter Checks	
	Room Checks During Sleep Period	Classification	
	Staffing	Behavior Management	
	Youth Movement & Counts	Self-Assessment	
	Fire Safety	Informed Consent	
	Staff Training	Treatment Planning	
	Admissions, Intake & Student Handbook	Transition Planning	
	Pending Placement	Environmental Hazards	
	Structured Rehabilitative Programming	Curriculum & Instruction	
	Intake, Screening & Assessment	School Environment & Climate	
		Health Assessments	

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Executive Summary of Results (Continued)

Superior Performance	Performance	Partial Performance	Non Performance
	Psychotropic Medication Management		
	Behavioral Health Services & Treatment Delivery		
	Documentation of Youth on Suicide Watch		
	Clinical Care for Suicidal Youth		
	School Entry		
	School Staffing & Professional Development		
	Screening & Identification		
	Individualized Education Programs		
	Career Technology & Exploration Programs		

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Executive Summary of Results (Continued)

Superior Performance	Performance	Partial Performance	Non Performance
	Student Supervision		
	Health Care Inquiry Regarding Injury		
	Medication Administration		
	Dental Care		
	Medical Records Retrieval		
	Special Needs Youth		

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Charles H. Hickey Jr. School

METHODOLOGY

I. Pre-Evaluation

Prior to the evaluation, the facility received a document request list from the DJS Office of Quality Improvement. This list detailed various documents in the areas of safety and security, medical care, mental health care and education that would be reviewed by the QI Team. Numerous on-site meetings have been held since the previous QI review in December 2007 including targeted QI reviews.

II. Entrance Interview with Superintendent

No entrance interview was conducted with the Superintendent. An overview of the QI process was provided to the Superintendent prior to the review and multiple interviews were conducted with the Superintendent throughout the week of the review. Members of the QI Team asked and discussed with the Superintendent targeted questions related to safety and security, behavioral health, behavior management, education, medical and many other areas of facility operation.

III. Primary Interviews

A total of 12 youth were interviewed (no refusals) about a range of areas across the QI review spectrum. This represented about 20% of the total population at Hickey that week (60 youth). The youth were chosen specifically across all units. Interviews were also conducted with facility direct care, administration, medical, behavioral health, and education staff. In addition, six staff were interviewed specifically about the target areas of the review as well as their general feelings about the operation of the facility.

IV. Document Review

Documents were reviewed that were requested by the QI Team and provided by the facility staff in support of facility operations and program services. The documents included medical records, incident reports, logbooks, program schedules, seclusion and suicide watch documentation, staffing reports, training records and statistical data, as well as other documents from areas in fire safety and youth supervision.

V. Observations of Facility Operations

- Youth movement
- Youth processing
- Structured programming
- Unit activities
- Recreation
- Leisure Time
- Classroom Activities
- Shift Change

VI. Exit Conference

An exit conference was conducted at the facility on Thursday, May 15th. Members of QI Team and the Administrative/Management staff of the facility were present. The QI team gave a brief but detailed overview of its findings. The facility administration had the opportunity to ask questions and to clarify or provide additional information. The Superintendent was given information about expectations for the Quality Improvement Plan (QIP), including due dates, and was informed he could expect the written Draft QI Comprehensive Report by June 5, 2008.

SUMMARY OF FINDINGS & RECOMMENDATIONS

SAFETY AND SECURITY

INCIDENT REPORTING **RATING: Performance**

STANDARD

Written policy, procedure and practice document that all incidents that involve youth under the supervision of DJS employees, programs, or facilities, including those owned, operated or contracted with DJS, are reported in accordance with departmental guidelines.

SOURCES OF INFORMATION

- Facility Incident Reports from Feb-May 2008
- Interview with Superintendent
- Youth grievances Feb-May 2008
- Staff Training records
- Interviews with youth
- Interviews with staff

REFERENCES

DJS Incident Reporting Policy (MGMT-03-07); DJS Crisis Prevention Management (CPM) Techniques Policy (RF-02-07); DJS Video Taping of Incidents Policy (RF-05-07); DJS Youth Grievance Policy (MGMT-01-07)

SUMMARY OF FINDINGS

Comprehensive and reliable reporting of incidents, including detailed descriptions of events, is crucial to a facility's success in preventing and managing critical situations. Only when youth feel they can report allegations and incidents confidentially and without reprisal, and staff members know how to document sufficient information in incident reports, can DJS feel confident in the implementation of its policies and the safety of our youth. The Department has a stringent reporting standard that requires completion of the DJS Incident Reporting Form to identify and describe all reportable and critical incidents.

The Department requires the facility to maintain an incident report (IR) file with detailed information about every incident. The IR file is to include a copy of the DJS Incident Reporting Form (handwritten and electronic) and supporting documentation (i.e. videotape, witness statements, Nursing Report of Youth Injuries with photograph(s), and other documentation as applicable). All IRs at Hickey were locatable and in organized files. In addition, their IR log was extremely useful in identifying with ease the IRs to review.

All of the staff were also able to describe their responsibility to complete an incident report if they are involved in an incident and to ensure that the involved youth is immediately taken to Medical for an assessment. All but two IRs reviewed included completed body sheets and photographs (more information on their quality is provided in the Health Care Inquiries Regarding Injury section of this QI report.)

Twelve incident reports (24% of the total for this time period) were chosen randomly for review specifically because they involved assaults, restraints, or suicide ideations. Of those 12 IRs, 9 (75%) were either rated as excellent or very good in quality. The narratives were descriptive enough so that a reader could visualize what occurred just by reading the series of events from the line staff's account and the description of the use of force, if there was one, was detailed and specific. In the other three IRs, staff used vague language about "intervening" that did not give enough detail to know what actually went on during the event.

Also positive is that all staff interviewed indicated that they receive feedback after submitting an incident report and/or that IRs are reviewed with them by senior management. One indicated that after filing an IR, she would receive a page and half of questions from the Superintendent, but she did not find this objectionable. She noted she had learned a lot from those notes and questions. It follows that the more feedback staff get, the less likely they are in the future to make the same mistakes and with Hickey's constant improvement in IR writing, it is evident that this has been the case.

Of the IRs reviewed, there were a total of 52 staff witness statements required to be included and just 9 (17%) were missing. Though the Shift Commander should not accept an IR until all staff witness statements are turned in with it, the vast majority of staff did include a witness statement.

In 3 of the 12 IRs, the youth who was involved in the incident did not have a witness statement included in the IR packet even if other youth did provide one. It is especially important that the actors in the event have an opportunity to write their version of the incident and that it is included in the packet.

The DJS incident reporting standard also requires that youth have the opportunity through a grievance process to report issues confidentially and without fear of reprisal. There were a total of 11 grievances written between mid-February and mid-May 2008. Of those 11, 1 was about missing points, 1 was about seeing the nurse, 1 was regarding getting a haircut, 2 were about the cottage temperature and 6 were about staff persons (3 about the same staff person.) In all, the grievances were picked up and responded to timely except one where the time lag was seven days.

The grievances all led to resolutions that seemed fair and that resolved the youth's complaint. In three, child abuse was alleged and properly reported and investigated by OIA and reported to CPS as required.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Ensure Shift Commanders review all IRs prior to accepting them to ensure they are complete and thorough, including all witness statements. Remind them of the vital importance of securing one from the participants in the incident.
- Ensure all staff complete IRs with sufficient detail so that the reader could re-enact the event just by reading the words on the page.
- Pick up all grievances immediately. If there is a delay for some reason, explain that delay and attach it to the grievance.

SENIOR MANAGEMENT REVIEW — RATING: Performance

STANDARD

Written policy, procedure and practice document that incident reports are reviewed and critiqued by shift commanders and critical documentation, such as incident reports, suicide watch and seclusion paperwork, are routinely audited by senior managers within DJS timelines and corrections are made by staff timely.

SOURCES OF INFORMATION

- Review of Incident Reports Feb-May 2008
- Interviews with staff
- Interview with the Superintendent

REFERENCES

DJS Policy MGMT-03-07 Incident Reporting Policy (MGMT-3-01); ACA 3-JDF-3B-10 and 3-JTS-3B-11

SUMMARY OF FINDINGS

The Senior Management Review (SMR) is a necessary component of the effective and efficient operation of detention facilities. Shift Commanders, Group Life Managers and Facility Administrative personnel offer a broad range of experience and insight into why incidents occur and how they can be prevented as well as about youth treatment and care and troubleshooting problem situations.

DJS Policy requires that an administrative review of an incident be completed within 48 hours. The SMR process is essentially a two part review: the first part consists of the initial Shift Commander's review/comments which constitutes a critique that is included in the incident report. The second part of the process takes place after the incident report is completed, and is done by staff at the Group Life Manager level or higher. This is the IR Audit. A final piece of oversight is the OIA (Office of Investigations and Advocacy) investigation process.

Initial Shift Commander Review:

The quality of the comments and critique in the IRs at Hickey is very good. Of the 12 IRs reviewed, only 1 had a shift commander comment the QI Reviewer would describe as poor (it simply noted was that staff were posted properly and in the IR, it looked as if staff weren't paying attention.) All of the others found ways to critique the line staff's response that were both helpful and appropriate.

In one, a shift commander identified the problem as being a power void left by a departing youth and the dissention that issue was causing on Clinton Hall. In another, the shift commander notes that a staff person shouldn't have left the classroom following one youth but instead should have allowed the hallway staff person to talk with him (a fight

occurred in the classroom when the staff left.) These kinds of informative comments by Hickey's experienced shift commanders assist in building a cohesive and knowledgeable line staff and are to be commended.

IR Audit:

The audits of the IRs at Hickey are primarily done by the Superintendent. The skill and ability he has in reviewing and finding targeted areas to critique is the highest the QI Team has encountered. Issues with staff posting, response, and other decision-making are carefully and skillfully brought out in these audits. Staff are not criticized or belittled but are left afterwards with a set of questions and notes that require answers and actions and in most cases, all staff comply by getting the information back to the Superintendent. Teaching moments are many and the Superintendent is sharing his considerable knowledge and insight in these audits. The new Assistant Superintendent is also beginning this process and it is clear she is being taught to be thorough and fair with staff.

Just 7 of the 12 IRs (60%) reviewed had been audited. However, the number not audited (considered Partial Performance) was balanced out by the quality of the ones that were audited (Superior Performance) so as to rate Hickey in the middle at an acceptable Performance rating. More work should be done to ensure all IRs are audited. There was one group disturbance on March 14th that had multiple actors and a lot of interesting information; staff would have benefited from seeing the leadership's view of their account of it.

For the 7 IRs and the associated audits reviewed, the length of time between incident and audit averaged 2.4 days, within the DJS policy requirements.

OIA Investigations: The Office of Investigations and Advocacy completed eleven investigations during the QI review period. All of the investigations reviewed responded to the corresponding IRs and all seemed to come to reasonable conclusions.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Complete audits for all IRs daily. If all or nearly all IRs had been audited, the rating for this standard would have been Superior.

DE-ESCALATION & RESTRAINT — RATING: Performance

STANDARD

Written policy, procedure and practice document the use of verbal crisis intervention techniques to de-escalate a situation prior to the use of physical restraints. Physical restraints are used only when necessary and the least restrictive physical restraint is used first. Incidents involving physical restraints are video taped.

SOURCES OF INFORMATION

- DJS Incident Reports from Feb-May 2008
- Facility training spreadsheet
- Interview with Superintendent
- Interviews with youth
- Interviews with staff

REFERENCES

DJS Incident Reporting Policy (MGMT-03-07); DJS Crisis Prevention Management (CPM), Techniques Policy (RF-02-07); DJS Video Taping of Incidents Policy (RF-05-07); ACA 1-SJD-3A-14-15

SUMMARY OF FINDINGS

DJS policy requires a continuum of interventions to be followed prior the use of physical restraint including verbal requests, non-verbal strategies, directive touch and related techniques. Physical restraint should be used as a last resort or if the youth poses an immediate and imminent threat to self or others or if the event of an attempted escape. In order to assess proper CPM technique, the QI Team reviews incident report narratives, videotapes and CPM training records, as well as information from staff interviews and statements from youth.

Youth overall indicated in interviews that staff break up fights when they occur. All staff indicated they always try verbal or other techniques prior to putting their hands on a youth. Staff indicated that they know and use CPM techniques they have learned and nearly all verbalized that de-escalation and the protection of all youth is their main priority when fights occur.

Ten incident reports (IRs) were also reviewed and all involved uses of force or a youth-on-youth assault. Of those 10 IRs, 80% were either rated as excellent or very good in quality. The narratives were descriptive enough so that a reader could visualize what occurred just by reading the series of events from the line staff's account and the description of the use of force, if there was one, was detailed and the physical action by the staff looked to be appropriate. In the other two IRs, the staff simply stated he "placed" the youth in his room and that a staff person "immediately intervened" and escorted the youth, but does not describe how.

Videotaping of incidents is a good way to review staff's use of physical restraint techniques. The Department's policy encourages the video recording of incidents as this is: 1) instrumental in evaluating the techniques(s) used during a physical restraint, especially without detailed narratives in the incident reports, 2) crucial in absolving staff of unfounded accusations of abuse (e.g. excessive force), and 3) useful as a training tool. Videotapes at Hickey are only sometimes available for incidents and tend to be absent for the same general reasons (battery dead, battery on charger, other staff had camera, etc.) Additional effort should be made to ensure that cameras are consistently available and operational on all units.

The QI Team reviewed five videotapes. One involved a popped sprinkler, one a pushed-out window. Two showed staff persons leading youth away from what likely would have turned into an incident in both cases. In one, the female staff allowed the youth to vent in the hallway and just listened, occasionally speaking to the youth and always in a calm voice. The male staff person in another incident led the youth away form an agitated group by his hand and shoulder calmly and appropriately. It was refreshing to see on video what the incident reports reflect happens in many circumstances. More experienced staff often seem able to de-escalate problems without the use of physical restraints, and the strategies caught on tape that they use should be shown to newer staff to help in training.

One incident on February 21st did lead to a physical restraint on the floor in the school. The incident report matched up to the events in the video, except that one staff person was seen in the video pulling the attacking youth's arm backwards at the elbow in a way inconsistent with proper CPM technique. The Superintendent indicated he has already spoken to that staff person about the incident.

DJS policy states that only an employee who has completed DJS approved initial training on the appropriate use of physical restraint and who can provide evidence of a semi-annual DJS approved refresher training on the appropriate use of physical restraint may implement physical restraint. Of the 56 mandated employees, 44 (78.57%) had completed Crisis Prevention and Management (CPM) training as required. In interviews, staff all indicated unanimously that they could not restrain or supervise a youth if they were not up-to-date with their training requirements.

RECOMMENDATIONS

In order to reach Superior Performance status, it is recommended that the facility:

- Provide refresher training to ensure that all staff are up to date on CPM training requirements. Require any staff that is past the six month CPM refresher period sign up for training immediately and follow up to ensure attendance until there is 100% compliance.
- To keep CPM techniques fresh after training, regularly quiz staff and ask them to demonstrate restraints for Shift Commanders and Senior Management. Observe techniques and provide on-the-spot coaching.

- Encourage more videotaping of incidents.
- Show videos of good de-escalation of youth at all-staff meetings so that newer staff can pick up the good skills of the more experienced staff. Ask the experienced staff to speak up about what they think works and why.

CONTRABAND & ROOM SEARCHES — RATING: Partial Performance

STANDARD
Written policy, procedure and practice document searches of rooms, youth and any contraband found. Incident Reports are written for contraband found in accordance with DJS policy.

SOURCES OF INFORMATION
Unit Logbook
Facility shakedown sheets
Interview with Superintendent
Observation at facility

REFERENCES
DJS Searches Policy (RF-06-07); Incident Reporting policy (MGMT-03-07); ACA 1-SJD-3A-16

SUMMARY OF FINDINGS

DJS policy requires youth rooms be searched a minimum of once per week. Policy also requires that all general areas are searched to include the school, cafeteria, medical, and dayroom. These and other searches ensure the safety of both staff and youth. Though contraband will often enter a facility by many means, there should be assurances that staff are trained to look for it and that they properly handle contraband when it is discovered.

DJS policy requires each facility establish a search plan (FOP) addressing the frequency of area searches, including but not limited to: General areas; Facility perimeter; Housing areas or rooms, program and non-program buildings/areas; and visiting areas. Based on an interview with the Assistant Facility Administrator, a FOP is being developed.

Based on interviews with youth and staff, room and general area searches are usually conducted at least once per week and daily, respectively. However, staff do not regularly document the searches on a shake down sheet or in the unit logbook, unless contraband is discovered. All room and general searches should be documented in order to track incidents of contraband to assist with determining its origin and to verify compliance with DJS policy. This also proves that the search occurred and there is less reliance on memory or oral assertions that it was done.

While on site, the QI team conducted a shakedown on Mandela Hall and found a brush and pencil under a mattress in a room. Also, several pencils were found in the drawer of a desk located in the center of the rear hallway. This desk is accessible to youth. There was no other contraband found.

DJS policy requires that at the entrance of all State-owned and State operated facilities, a

warning notice be posted informing individuals who enter the facility that they are subject to a search at any time. The Hickey School has a sign of this nature posted near the entrance to the facility.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Staff should document all room and general area searches on a shake down sheet every time they occur and file them. Logbooks and shake down sheets should indicate the time and date the search was conducted, by whom and any items found and in what locations.
- Ensure youth who request pencils to write letters or do schoolwork return it that same day. Create a list of writing implements that go out and check off when they come back to track them, if necessary. Keep extra pencils in a locked office.
- Complete and disseminate to the search plan FOP to staff.

SECLUSION — RATING: Partial Performance

STANDARD

Written policy, practice and procedure provide that youth confined to a locked room, not during sleeping hours, shall be observed often and have those observations documented, shall only be placed in seclusion if they present an imminent threat to others, a substantial destruction to property or an imminent threat of escape, and shall be treated humanely and with concern and care so as to safely maintain the youth until he can be released in the least amount of time.

SOURCES OF INFORMATION

- Facility Seclusion Log
- Seclusion Observation forms Feb-May 2008
- Interviews with Superintendent
- Interviews with youth
- Grievances Feb-May 2008
- Interviews with staff
- Observation at facility

REFERENCES

DJS Seclusion Policy RF-01-07; COMAR 16.18.02

SUMMARY OF FINDINGS

DJS policy authorizes the use of seclusion only when youth present an imminent threat to self or others are an imminent escape risk, or when less restrictive measures of control have not been successful. Seclusion cannot be used as punishment and must be documented according to policy. There is no prescribed length of time in seclusion due to its lack of a punishment aspect, but policy is clear that at certain intervals, youth either must be re-assessed, checked by mental health, documentation prepared as to extensions or (as in the case after 72 hours) released altogether.

Seclusion documentation from Hickey indicates that seclusions are rarely occurring. From February11-May 11, 2008 there were only six (6) instances of documented seclusions. Three (3) of those seclusions occurred on the same day where three (3) youth attempted to abscond from the facility.

Observation forms for the three (3) youth who attempted to abscond from the facility indicated that staff were not performing checks in "staggered intervals," as outlined in the DJS policy. A majority of the checks were in exact ten minutes intervals.

These three youth also were in seclusion for about 37 hours each, but were all released within five minutes of one another. This gives the impression that the seclusion may have been used as punishment, though it is also as likely that the investigation into their

attempt had to be completed before they were released in order to ensure they did not attempt again. Though present in this case, no patterns emerged that this practice was a problem at Hickey. Additionally, DJS policy requires that in instances where seclusions last more than eight hours, the facility administrator or designee shall "notify the Assistant Director of Investigations via electronic mail, referencing the DJS Incident Tracking Number associated with the initial report." In these youth's cases, this information was not observed in the seclusion file.

Shift Commanders (SCs) are required to visit youth in seclusion every two hours and assess whether they are ready to be released into the population. Their comments are included on the Seclusion Observation Form. SC comments were for the most part appropriate. One comment in particular stated that "student states that he don't feel like talking and when he does he will call for me." This is an excellent comment and gives a good justification for not releasing the youth. On the flip side, there was an occasion where the SC's comment was "student remains because he is a risk." Although the youth did attempt to AWOL, the SC's comments need to be more descriptive with regards to the youth's actual behavior and reason for not releasing him.

During the twelve youth interviews, only two (2) youth reported that they had been placed in seclusion (and for less than four hours) for fighting. Several youth on Ford Hall mentioned that they went to bed at 6pm. The daily unit schedules at Ford Hall indicated the earliest bedtime for youth was 8:30pm; therefore, sending the youth to bed at 6pm would in fact constitute seclusion and would have to be documented accordingly; there was no seclusion documentation for Ford Hall for 6-8pm on any dates. The administration immediately addressed this issue the day the QI Team was there and a memo was issued on May 14, 2008 directing that staff not commence bedtime lock-ins until 8pm.

On March 14, 2008 a group disturbance occurred where a unit lockdown was approved by administration, which seemed like a wise decision. However, there were no documented seclusions in the log for this day, and no sheets to review. In light of the multiple fights and the unit lockdown authorization, the QI Team was able to piece together that for at least an hour (if not likely more) these youth were in their locked rooms, and so seclusion paperwork and procedures would have had to kick in.

Policy also requires medical checks to be conducted every two hours while a youth is in seclusion. There were 2 instances observed on the overnight shift where a medical check had not been conducted. In most cases, medical checks were done as required.

Finally, five (5) staff interviews revealed that all but one staff member could provide a detailed explanation of the process for secluding youth. The remaining staff interviewed was still able to give a general description of the procedures. In facilities where seclusion is becoming less prevalent, staff may actually need refresher training at regular intervals so that when they have to seclude a youth, they know exactly what procedures to follow.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Review seclusion paperwork daily so that staff and managers are aware of all seclusion-related documentation abnormalities immediately.
- Require Shift Commanders to contact the nurses when they see medical has not completed their two hour check timely.
- Whenever unit lockdowns are approved by administration, make sure that staff are following the proper procedures; if a youth is placed in his room with the door locked and it is not bedtime, regardless of the length of stay, a seclusion sheet and proper seclusion practices must immediately commence.
- Ensure the practice of "early bed" does not continue on Ford Hall. Check Guard Tour data regularly and check logbooks for bedtimes of youth.
- In light of the low rate of seclusion use, consider refreshers on seclusion procedures for staff at regular intervals so that they can immediately recall the steps they must take when a youth in secluded.

ROOM CHECKS DURING SLEEP PERIOD	RATING: Performance

STANDARD

Written policy, procedure and practice document that staff visually check the safety and security of each youth at least every 30 minutes during the sleep period, unless instructed to check more often due to the status of the youth. Room checks during sleep period document the youth's name and the time the check was conducted

SOURCES OF INFORMATION

- Interviews with staff
- Logbooks
- Room check sheets
- Guard Tour documentation

REFERENCES

DJS Youth Movement and Counts Policy RF-02-06; ACA 3-JDF-3A-04 and 3-JTS-3A-04; Cheltenham's FOP (Room Checks) dated January 16, 2008.

SUMMARY OF FINDINGS

Room checks of youth after bedtime are vital to ensure the safety of youth. Checking a youth often means the staff is aware of where each young man is at all times and that youth who might want to harm themselves are not left for extended periods of time unobserved.

DJS policy and the Charles H. Hickey Jr. School (Hickey) has a Room Check Facility Operating Procedure (FOP) that requires a visual room check of each youth at least every 30 minutes, or more frequently as determined by supervisory, mental health or health care staff. Hickey primarily utilizes the Guard Tour electronic system to document visual checks of each youth during sleep periods. Interviews with the Assistant Facility Administrator and staff, along with a review of data (i.e. logbooks and Guard Tour) from 76 randomly selected shifts for the period of February 11 to May 11, 2008 revealed that room checks for the most part were documented at 30 minute increments.

A review of Guard Tour data revealed that there were occurrences where room checks exceeded the 30 minute increment by more than an hour. For example, on May 5, 2008, Clinton Hall missed a room check by 3.5 hours, and Ford Hall missed a room check by 61 minutes. It is imperative that youth are observed during sleep periods in accordance with DJS policy to ensure their safety and not left unobserved for extended periods of time.

The Facility's Room Check Operating Procedure requires that in the event there is a malfunction with the Guard Tour system, the staff should immediately notify the Shift

Commander and immediately begin recording observations on the Sleep Observation Sheet (Room Check Sheet). A review of unit logbooks revealed that on April 15, 2008, Clinton Hall's staff stopped using the Guard Tour Pipe because it was full, and on May 3, 2008, the Guard Tour Pipe was not available until 12:30am. No Room Check Sheets were found for these dates and times.

Guard Tour pipes should be downloaded and the data reviewed on a daily basis so discrepancies can be quickly identified and addressed. Hickey's FOP cites that Unit Managers/Shift Supervisors shall ensure that each Guard Tour "pipe" is downloaded at least once daily at the beginning of the daytime shift. It appears that on only one day reviewed, April 15, 2008, the pipe was not downloaded pursuant to those FOP guidelines. There was no documentation regarding any disciplinary action available for review in regards to this failure to download the pipe as required and no Room Checks Sheets were available for this date either.

Hickey's Room Check Sheets contain preprinted room check times that are listed in 30 minute increments (i.e. 7:00; 7:30; 8:00; 8:30; etc). Since room checks should accurately reflect the time that a youth and room was checked, Room Check Sheets with pre-printed times are not suitable for recording the exact time of observations. These should be destroyed, new sheets created without pre-printed times, and a supply of them kept in each cottage manager's office to be used when the Guard Tour system is not operational.

The FOP requires that room checks begin upon the youth entering his room for the night and continue until hygiene begins. A review of the unit logbooks revealed that often staff documented the use of the Guard Tour system coinciding with a youth's scheduled bedtime (i.e. April 14, 2008, Clinton Hall stated showers at 8:20pm and using the Guard Tour system at 8:30pm.). But there were also several incidents in which the Guard Tour system was not initiated until about 10:00pm.

The Facility's Room Check Operating Procedure requires that staff log Guard Tour rounds *[not their observations]* in the logbook. A review of unit logbooks revealed that staff typically document Guard Tour rounds in the unit logbooks according to the FOP.

RECOMMENDATIONS

In order to reach Superior Performance status in this area, it is recommended that the facility:

- Remind staff of the importance of conducting and documenting room checks every 30 minutes (and as soon as youth go into their rooms for bedtime) as is required by DJS policy and Hickey's FOP.
- Have Unit Managers/Shift Supervisors conduct a daily review of their staff's Guard Tour data.
- Forward all discrepancies and failures to meet the FOP requirements immediately to the Superintendent for follow-up and corrective action. Document progressive discipline for staff consistently missing room checks.

- Stop using the Room Sleep Sheets with pre-printed times. Room Check Sheets with pre-printed times should be destroyed, new sheets created without pre-printed times, and a supply of them kept in each cottage manager's office to be used when the Guard Tour system is not operational.

PERIMETER CHECKS — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document daily security checks of the perimeter to include, at a minimum: a check of all locks, windows, doors, fences, gates, security lighting, security devices, and a check of outdoor areas, gates and security fences to ensure they are secure, free from contraband and have not been tampered with.

SOURCES OF INFORMATION

Facility and Perimeter Tour
Observations
Logbooks
Guard Tour documentation
Interviews with Director of Group Life and staff

REFERENCES

DJS Perimeter Security Policy RF-09-07, Maryland Standards for Juvenile Detention Facilities; ACA 3-JDF-3A-12, 2G-02, 3-JTS-3A-12 and 2G-02, Cheltenham's FOP (Perimeter Checks) dated January 12, 2005.

SUMMARY OF FINDINGS

Regular perimeter checks are an important aspect of safe facility management. Fence breaches, unlocked doors and damaged gates can lead to escapes. DJS policy requires that searches of the perimeter and grounds be conducted on a daily basis to ensure that there are no immediate breaches of security or visible contraband. The facility currently does not have a Perimeter Check FOP. The Assistant Facility Administrator is in the process of completing one.

Based on interviews with the Assistant Facility Administrator and staff along with a review of the Gatehouse's log book and the Zone/Unit Inspection sheets, inspection of the perimeter fence occurs 2 to 6 times on a daily basis. However, a review of Guard Tour data revealed instances when the Guard Tour system was not used to document a perimeter fence check as recorded on a Zone/Unit Inspection sheet(s). For example, on March 14, 2008, 4 perimeter fence checks were documented on Zone/Unit Inspection sheets, but only 1 fence check was documented with the use of the Guard Tour system for that day; on May 10, 2008, 5 perimeter fence checks were documented on Zone/Unit Inspection sheets, but none of the fence checks were documented with the Guard Tour system on the same day. Only the Guard Tour system should be used to document perimeter checks since it is more reliable than using the sheets. It was unclear why the staff are using this alternate form for perimeter checking when the electronic system is available to them.

Based on interviews with staff and a review of unit log books, staff assigned to housing units conduct perimeter checks (outside and inside) of their respective units on a daily

basis. Although the unit's perimeter checks are logged in the log book, the facility's Zone/Unit Inspection sheet should be utilized to articulate what items (i.e. locks, windows, doors, etc.) or security devices were examined during the perimeter check. (Note: There is no Guard Tour system outside each cottage.)

Currently, the security level of the perimeter checks has been enhanced by a mobile fire watch patrol due to the fire alarm system needing repairs. The mobile fire watch patrol conducts perimeter checks of specified buildings and areas throughout the facility in 15 minute increments.

A member of the QI Team observed a small amount of leaves along the fence line adjacent to Mandela Hall and two large piles of leaves behind Clinton Hall. Removal of the leaves would aid staff in observing any contraband during a visual inspection of the areas, and is recommended.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Complete and disseminate a FOP regarding perimeter check procedures.
- Have staff members who conduct perimeter fence checks use the Guard Tour system only to document the checks. If it is not operational, ensure they explain why not in the unit log book and to the shift supervisor, and that they then use the Zone/Unit Inspection sheets as a backup.
- Request that Maintenance remove any and all leaves/debris from along the fence line and behind unit(s).

STAFFING — RATING: Performance

STANDARD

The facility maintains a current staffing plan that ensures a sufficient number of staff is present to provide an environment that is safe, secure and orderly.

SOURCES OF INFORMATION

- Facility staffing list including vacancies
- Facility Logbooks
- Shift schedules for six random days
- Interview with Superintendent
- Observation at facility

REFERENCES

ACA 1-SJD-1C-03

SUMMARY OF FINDINGS

Consistent coverage of facility shifts is vital to the safety and security of DJS youth. Only with enough well-trained staff can the youth be afforded solid supervision as well as access to education, programming and recreation. The staffing ratio at Hickey is 1:8. This ratio is within professionally accepted standards.

The Charles Hickey School is a 72 bed facility with Mandela, Clinton and Ford Hall able to house 24 residents. Hickey has another unit, Roosevelt Hall, which is currently closed so it is not included in this report. The Charles Hickey School provided a list of their direct care staff by Date of Entry on Duty and Classification and the daily population counts for the three housing units, Clinton, Mandela and Ford Hall (which consists of the Infirmary Unit and Orientation Unit.) Finally to support that adequate staffing was maintained, Hickey provided copies of the three units' log books for the dates requested.

Among the information provided by Hickey, as of May 1, 2008 Hickey had a total of 103 Direct Care Staff and 8 Case Managers. Their classifications are as follows:

POSITION CLASSIFICATIONS	AMOUNT
GROUP LIFE MANAGER I	**7**
RESIDENT ADVISOR SUPERVISOR	**5**
RESIDENT ADVISOR LEAD	**11**
RESIDENT ADVISOR II	**55**
RESIDENT ADVISOR I	**17**
RESIDENT ADVISOR TRAINEE	**8**

TOTAL # OF DIRECT CARE STAFF	103
CASE MANAGEMENT SPECIALIST SUPERVISOR	2
CASE MANAGEMENT SPECIALIST III	4
CASE MANAGEMENT SPECIALIST II	1
CASE MANAGEMENT SPECIALIST I	1
TOTAL # CASE MANAGEMENT SPECIALIST	**8**

After a review of the log books on the random dates requested, it was found that on Clinton Hall, on February 16, 2008 during the 6am-2pm shift and on March 26, 2008 during the 2pm-10pm shift, staff were out of ratio for a period of time. This was quickly identified by the leads and corrected. During most of the youth's waking hours, the facility provides each unit with a Resident Advisor Supervisor or Lead to ensure that adequate safety and security is maintained at all times.

LOG BOOK SHOWING WHO REPORTED FOR WORK ON ALL SHIFTS					
UNIT:	**CLINTON HALL**				
Date Requested:	**Shift**	**# of Youths**	**# of Staff**	**Classification**	**Additional Notes**
2/16/2008	6am – 2pm	**25**	**4**	2 RA Leads; 1 RAS; 1 RA II	Out of ratio in early am but corrected.
	2pm – 10pm	**26**	**4**	1 RAL; 3 RA II;	
	10pm – 6am	**26**	**2**	2 RA II	
2/22/2008	6am – 2pm	**23**	**3**	1 RAL; 2 RA II;	
	2pm – 10pm	**23**	**4**	1 RAL; 3 RA II;	
	10pm – 6am	**22**	**2**	2 RA II	
3/9/2008	6am – 2pm	**21**	**3**	1 RAL; 2 RA II	
	2pm – 10pm	**23**	**3**	1 RAL; 1 RA II; 1 RA Trainee	
	10pm – 6am	**22**	**3**	3 RA II	
3/26/2008	6am – 2pm	**24**	**4**	2 RAL; 2 RA II;	
	2pm – 10pm	**25**	**4**	3 RA II; 1 RA T	Out of ratio during programming but corrected during the shift.

	10pm – 6am	**25**	**2**	1 RA II; 1 RA T	
4/22/2008	6am – 2pm	**24**	**4**	1 RAL; 2 RA II; 1 RA I	
	2pm – 10pm	**24**	**5**	1 RAL; 2 RA II; 1 RA I; 1 RA T;	**1- SWL 3**
	10pm – 6am	**24**	**3**	3 RA II;	**1-SWL 3**
5/1/2008	6am – 2pm	**23**	**4**	1 RAL; 2 RA II; 1 RA I;	
	2pm – 10pm	**24**	**4**	4 RA II	**1-SWL 3**
	10pm – 6am	**22**	**3**	3 RA II	**1-SWL 3**

The same dates were requested to perform an assessment of staff to youth ratio on Mandela but the facility was unable to locate the February 16, 22 and March 9, 2008 documentation. On the other three dates provided, documentation shows that the 1:8 ratio was maintained at all times.

#10: LOG BOOK SHOWING WHO REPORTED FOR WORK ON ALL SHIFTS					
UNIT:	**MANDELLA HALL**				
Date Requested:	**Shift**	**# of Youths**	**# of Staff**	**Classification**	**Additional Notes**
2/16/2008	6am – 2pm				
	2pm – 10pm	UNABLE	TO	LOCATE	
	10pm – 6am				
2/22/2008	6am – 2pm				
	2pm – 10pm	UNABLE	TO	LOCATE	
	10pm – 6am				
3/9/2008	6am – 2pm				
	2pm – 10pm	UNABLE	TO	LOCATE	
	10pm – 6am				

3/26/2008	6am – 2pm	**26**	**4**	1-RAL; 3-RA II;	
	2pm – 10pm	**26**	**4**	1-RAL; 2- RA II; 1-RA I	
	10pm – 6am	**25**	**2**	1 RA II; 1 RA I;	
4/22/2008	6am – 2pm	**28**	**4**	4- RA II	
	2pm – 10pm	**28**	**4**	4- RA II	
	10pm – 6am	**28**	**2**	2-RA II	
5/1/2008	6am – 2pm	**24**	**3**	1-RAL; 2-RA II;	
	2pm – 10pm	**24**	**3**	1-RAL; 2-RA II;	
	10pm – 6am	**24**	**2**	2-RA II;	

Ford Hall is divided into an Infirmary Unit on one dorm side and an Orientation Unit on the other. The Infirmary Unit houses youth that need additional care and/or increased level of supervision due to being medically fragile, in protective custody, on a guarded care plan and sometimes for those on a suicide watch level.

The documentation reviewed in the log book does not state which staff are assigned the to 1-on-1 supervision but it appeared that the unit was out of ratio twice on the four days provided at particular times during the day. It is very important for the documentation to be clear and concise for this unit to ensure that supervision and adequate care is being provided to this high risk youth population. During the QI Reviewer's observation on the unit, the Infirmary youth and Orientation youth are at times receive different programming during the course of the day. Hickey only keeps one log book for this unit so it is unclear at times which staff are assigned to Orientation or the Infirmary to determine whether the appropriate ratios are being maintained.

#10: LOG BOOK SHOWING WHO REPORTED FOR WORK ON ALL SHIFTS							
UNIT:	**FORD HALL**						
Date Requested:	**Shift**	**# of Youths**		**# of Staff**		**Classification**	**Additional Notes**
		INF.	**ORIEN**	**INF.**	**ORIEN**		
2/16/08	6am – 2pm						

	2pm – 10pm					UNABLE TO	LOCATE
	10pm – 6am						
2/22/08	6am – 2pm						
	2pm – 10pm					UNABLE TO	LOCATE
	10pm – 6am						
3/9/08	6am – 2pm	**6**	**8**	**2**	**2**	**1-RAS; 2-RA II; 1 RA I;**	**Inf.-1-SWL 3**
	2pm – 10pm	**6**	**4**	**2**	**1**	**1-RAS; 2-RA II;**	**Inf.-1-SWL 3**
	10pm – 6am	**6**	**4**	**2**	**1**	**1-RAL; 2-RA II;**	**Inf.-1-SWL 3**
3/26/08	6am – 2pm	**4**	**16**	**1**	**3**	**1-RAS; 1RAL; 2-RA II;**	**Inf.-1-SWL 3**
	2pm – 10pm	**4**	**14**	**1**	**3**	**1-RAS; 1RAL; 2-RA II;**	
	10pm – 6am	**4**	**14**	**1**	**2**	**1 RAS; 2-RA II;**	
4/22/08	6am – 2pm	**1**	**10**	**1**	**3**	**1-RAS; 3-RA II;**	
	2pm – 10pm	**2**	**7**	**1**	**2**	**1-RAS; 1-RA I; 1-RA II;**	
	10pm – 6am	**2**	**7**	**1**	**1**	**2-RA II;**	
5/1/08	6am – 2pm	**2**	**12**	**2**	**3**	**1-RAL; 4-RA II;**	**Inf.- 1-SWL 2 Orient. -2-SWL 2 + 1 SWL3**
	2pm – 10pm	**2**	**12**	**2**	**4**	**1-RAT; 3-RA II; 1-RAS; 1-RA I**	**Inf.-1-SWL 2 Orient. -2-SWL 2 + 1 SWL3**
	10pm – 6am	**2**	**12**	**1**	**3**	**1-RA I; 2-RA II; 1-RAS;**	**Inf.-1-SWL 2 Orient. - 2-SWL 2+ 1 SWL3**

RECOMMENDATIONS

In order to reach Superior Performance status, it is recommended that the facility:

- Hold Shift Commanders accountable for maintaining safe staffing ratios throughout the shift and verifying all information is noted in unit log books.

- Develop a system for the filing of completed log books that includes storing them in a central location for ease of review.
- Train staff on log book documentation and how vital all of the information that affects their shift should be documented.
- Consider separate logbooks for Orientation and the Infirmary.

CONTROL OF KEYS, TOOLS & ENVIRONMENTAL WEAPONS	RATING: Non Performance

STANDARD

Written policy, procedure and practice provide for the control of tools and equipment that could be used as weapons or for other dangerous purposes. There is system that ensures strict accountability of the receipt, usage, storage, inventory, and removal of all toxic and caustic materials.

SOURCES OF INFORMATION

- Facility Tour
- Interview with staff
- Key Inventory
- Tool & Sharp Objects Inventory

REFEERENCES

DJS Key Control Policy RF-06-05; DJS Perimeter Security Policy RF-09-07, ACA 3-JDF-3A-22 and 3-JTS-3A-22

SUMMARY OF FINDINGS

KEYS:

DJS policy requires all staff be provided with a metal key chit that is exchanged for receipt of facility keys and that incoming staff receive keys in exchange for their chit. This facility's key control system does not establish strict accountability for all keys according to DJS guidelines. Staff are provided facility keys without a chit and for the most part, unit keys are exchanged among unit staff at the beginning of each shift and the exchange is simply documented in the unit log book.

DJS policy requires that facilities maintain a Working Key Board that contains keys issued on a regular basis, and a Back-up Key Board containing back-up and pattern keys which should be located in a secure location. This facility does not have a Working Key Board. The Maintenance Section reportedly has a key to every lock at the facility. There is no full set up Back-up keys kept at a secure location off-site either.

TOOLS AND ENVIRONMENTAL WEAPONS:

Since the daily operation of the facility requires staff to have access to various tools, culinary, cleaning and medical equipment, a system of internal accountability should be maintained in order to always account for these items so as to maintain facility safety.

The Medical Unit maintains a perpetual inventory system that tracks the number of hypodermic needles used and stored. All hypodermic needles and other sharp instruments are stored in a locked cabinet.

The West Campus Dining Hall's inventory system does not identify the name of the knives and utensils stored. The knives and utensils are stored in a container which is locked in a large cabinet. No master inventory list of the Knives and utensils was available for review. The current sign in/out system does not identify the name (type) of knife or utensil signed out. It is recommended that the name or type of the knives and utensils be identified in the inventory and then identified when they are signed out.

During a tour of the units, a QI team member observed a bathroom door open on two occasions in Mandela Hall. Doors should remain locked at all times to avoid youth being in a room alone without supervision and to secure soaps and other ingestibles from youth on the unit.

The Maintenance Section was not available for inspection during this review period.

RECOMMENDATIONS

In order to reach Partial Performance status in this area the following is recommended:

- Adhere to the Department's Key Control policy.
- Assign chits to all employees. These chits should be used for the retrieval and return of keys. Informal systems for attaining keys should be discouraged.
- Write a FOP for the control and inventory of Tools/Environmental Weapons and Key Control.
- Establish a sign in/out system to track the use of all Tools/Environmental weapons at all locations throughout the facility.

YOUTH MOVEMENT & COUNTS — RATING: Performance

STANDARD

Written policy, procedure and practice document a system for physically counting youth. Youth movement is orderly and provides for identifying each youth movement and the specific location of each youth at all times. Formal and informal headcounts are conducted and documented in accordance with departmental guidelines. Emergency counts are conducted and documented when necessary.

SOURCES OF INFORMATION

- Logbooks
- Interviews with staff
- Interviews with youth
- Observation of youth movement

REFERENCES

DJS Youth Movement and Counts Policy RF-02-06; ACA 3-JDF-3A-13 & 14 and 3-JTS-3A-13 & 14

SUMMARY OF FINDINGS

Based on interviews with staff, observations of youth movement, and a review of Master Control and unit logbooks, youth movement is generally orderly and is consistent with the 1:8 staff to student ratio.

The facility conducts head counts multiple times throughout the day, however the documentation is not done according to DJS policy. All units are documenting thirty minute checks throughout the day in their individual log books but the day and evening shifts are not consistently calling in the count to Master Control after each one is conducted. DJS Policy directs facility staff to "conduct counts every 30 minutes and call the count into the Command Control Center/Master Control/Tour Office." The night shift was consistently calling in their checks after each count. DJS Policy also requires the facility to conduct an official count at 2am which must be called in (Cheltenham Youth Facility takes these counts at this time) by 8am. This practice of conducting an official count and calling it in each morning was consistently observed in the Master Control log.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Ensure each unit calls in all administered counts into Master Control as required by policy.

FIRE SAFETY — RATING: Performance

STANDARD

Written policy, procedure and practice document the facility's fire prevention and safety precautions in accordance with departmental guidelines. Provisions for adequate fire protection service provide for the availability of fire protection equipment at appropriate locations throughout the facility and the control of all use and storage of flammable, toxic, and caustic materials.

SOURCES OF INFORMATION

- Facility Tour
- Interviews with staff
- Interviews with the Superintendent
- Interviews with maintenance staff
- Review of Logbooks
- Examination of Fire Safety Equipment
- Fire Drill Documentation

REFERENCES

DJS Policy MGMT-3-01; ACA 3-JDF-3B-05, ACA 3-JDF-3B-10 and 3-JTS-3B-11

SUMMARY OF FINDINGS

Clear fire safety procedures, regular fire drills and maintained fire equipment are necessary to ensure the safety of the youth and staff at any facility and are also required by Maryland Code.

Based on a review of the Maryland State Fire Marshal's report, Fire Alarm System maintenance records, and interview with the Facility Administrator, several buildings, to include some housing units, do not have a functional audio fire alarm that is connected to a centralized alert system at the facility. The alarm panels in nine buildings are obsolete and parts are no longer available to repair the panels.

This issue was discovered prior to the QI Review Team's visit. In response, the Facility Administrator immediately began a mobile fire watch patrol that is still in progress. This patrol currently conducts periodic checks every 15 minutes, 24 hours a day and 7 days a week of all buildings and areas that are not properly alarmed. All information relative to the fire watch patrol is documented in a logbook. Replacement of the antiquated fire alarm system should begin sometime this year and bids are currently being sought. Though the malfunction of the fire alarm system is not ideal, the fire watch process put into place by the facility is ensuring the youth's safety and is being properly done. There were no problems noted to these buildings' smoke and heat detectors, flow switches or pressure switches.

A review of facility maintenance and fire drill records along with observations and interviews of staff and youth revealed that this facility practices sound fire safety procedures. Fire drills are documented and staff and youth alike say they are routinely conducted. All units have a sprinkler system in areas that house youth who sleep overnight, or a fire watch in process. Fire extinguishers are serviced annually and checked on a monthly basis according to departmental guidelines.

"Key Touch" is an important skill. It allows the facility staff to be able to touch or feel a key without looking at it and by touch, know which door it unlocks. During a tour of the facility, two randomly selected staff were able to unlock and open a fire exit door without having to look at the key. However, there was difficulty unlocking the door with one of the keys. Hard-to-open and inoperable doors/locks pose a serious safety issue in the event of a real emergency. It is therefore imperative that keys and locks are frequently checked and immediately fixed when problems are discovered.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Complete the installations of the new fire alarm system.
- Routinely check the function of keys and locks to ensure all are in proper working order.

POST ORDERS	RATING: Non Performance

STANDARD:
Written policy, procedure, and practice provide post order for security post and key staff positions. Staff members are familiar with roles and responsibilities of the post order prior to assuming the post. Post orders are current. Shift commanders ensure that post orders are reviewed by the staff member. Post order signature sheet is signed by the staff assuming the post and initial by the immediate supervisor.

SOURCES OF INFORMATION:
- Facility Tour
- Review of logbooks
- Interviews with facility administrators

REFERENCES:
DJS Post Orders Policy RF-07-07; ACA 3-JDF-05, 3-JDF-3A-06, 3A-JDF-3A-07

SUMMARY OF FINDINGS:

A post is a place or function to which staff members are assigned to ensure a safe, secure and orderly environment. Post orders are a written set of instructions, requirements, and guidelines for staff to follow to ensure the effective operation of an assigned post to promote the safety and security of the facility, youth and staff.

DJS policy states that at a minimum Post Orders shall be established for the following staff positions: (a) Resident Advisor (b) Resident Advisor Lead, (c) Resident Advisor Supervisor, (d) Shift Commander (e) Security; and (f) Special duty/assignment positions (i.e. key control, supply, safety officer or emergency management officer) and that a copy of each Post Order be maintained on or near each post and at the Command Control Center/Master Control.

DJS policy further requires each facility establish Post Orders, as applicable, for: Housing Units, Admissions, Multi-purpose room, in/out door recreation areas, Transportation, Health Services Unit, Dining area, Laundry, Supply, Visitation, Command Control Center/Master Control, Hospital and off-property appointments; and Maintenance Shop. Each Post Order shall include, the name of the facility, name of post including location, date of post order, times post is manned, number of staff assigned to post, detailed description of duties, including equipment needed, when post may be collapsed and who may authorize, facility Administrators signature and date, indicating approval of post order, last review date and next review date; and Post Order Signature sheet.

Based on interviews with the Assistant Facility Administrator, Facility Administrator, and staff, this facility simply does not have post orders established according to DJS

policy. The facility is currently developing post orders to comply with departmental guidelines. They will be assessed at a future targeted review.

RECOMMENDATIONS

In order to reach Performance status in this area, it is recommended that the facility:

- Adhere to the Department's Post Order policy. At a minimum, establish and disseminate post orders for the staff positions and posts as delineated by DJS policy.

STAFF TRAINING — RATING: Performance

STANDARD

Written policy, procedure and practice provide that all full-time staff who have regular and daily contact with juveniles receive organized, planned and evaluated trainings in accordance with departmental guidelines. Training is designed to develop the employee in job specific learning objectives.

SOURCES OF INFORMATION

- Discussion with the Superintendent
- Facility training spreadsheet records
- OPDT training records

REFERENCES

Maryland Correctional Training Commission (MCTC); ACA 1-SDJ-1D-03, ACA 3-JDF-1-D-01, ACA-JDF-1D-02

SUMMARY OF FINDINGS

The Office of Professional Development and Training at DJS and individual facility Training Coordinators work in concert to ensure that facility staff are trained to do their jobs and are MCTC-certified while working with the youth in our care. Classes in Crisis Prevention and Management (CPM), Suicide Prevention, Reporting and Recognizing Child Abuse, Cardiopulmonary Resuscitation (CPR), and other classes are required semi-annually or annually by all direct care staff. DJS requires 40 hours of refresher trainings each year and 18 hours of that are required by the MCTC (Maryland Correctional Training Commission.)

The Charles H. Hickey School, Jr. (Hickey) staff has been scheduled for a number of trainings since February of this year (2008). The training Administrator provided the Professional Development and Training Unit (PDTU) with training schedules from February 2008 to June 2008. Of the 56 mandated staff at Hickey, the numbers of staff who have completed the indicated trainings are:

#	% completed	Training Subject
50	89.29%	Adolescent Mental Health/DD
48	85.71%	Behavior Management
40	71.43%	Blood borne Pathogens
48	85.71%	Recognizing and Reporting Child Abuse
44	78.57%	Crisis Prevention and Management
38	67.86%	CPR/Standard First Aid
47	83.93%	Report Writing
49	87.50%	Suicide Prevention and Awareness
49	87.50%	Verbal De-Escalation

Out of the 56 mandated staff, 47 are certified, 4 are provisionally certified and 5 are not certified. Of the nine staff who are in provisional or non-certified status, 8 have completed Entry Level Training (ELT). Four of the provisionally certified staff need field training (FT) verifications. One staff person has completed ELT on 5/2/08 and FT 5/15/08, but is not provisionally certified.

An average, 71% of the Hickey staff have completed over 81% of the mandated training modules, including the ELT participants. The Training Administrator has not compiled the mandated training schedule for the next two quarters and should do so in order to keep staff trained and to assist the Superintendent in future shift scheduling.

RECOMMENDATIONS

In order to reach Performance status, it is recommended that the facility:

- Require the Training Administrator to compile the mandated training schedules for the next two quarters and submit them to the PDTU.
- Adhere to the in-service training schedule developed to ensure that staff meet the requirements for annual in-service training.
- Develop an internal audit system to check staff records for training deficiencies in order to "catch" the training hour deficiencies before they become overwhelming. Consider requiring bi-weekly updates on status to the Superintendent as a part of self-assessment meetings.
- Require the four Hickey staff who have not attended any in-service training thus far to be put on the schedule immediately and be made aware of the importance of the mandated training and of MCTC compliance.

ADMISSIONS, INTAKE & STUDENT HANDBOOK	RATING: Performance

STANDARD

Written policy, procedure, and practice provide that the admissions process in each detention is operated on a 24 hour basis. The admissions process documents all required elements of the admissions. Such required elements include the initial search of the youth, verification of legal status, verification of basic identifying information, search of ASSIST database to obtain all legal history, photograph of youth upon admission, telephone call, classification, identification, student handbook, clothing and state issued items, and movement to the unit.

SOURCES OF INFORMATION

- Review of the Facility Intake Packet
- Review of Facility Handbook
- Interview with Intake staff
- Interviews with youth

REFERENCES:

Admissions and Orientation Policy RF-03-07; Maryland Standards for Juvenile Detention Facilities; DJS Classification Policy in final editing stage; ACA 3-JDF-5A-02, 3-JTS-5A-01, 5B-01 through 04 and 5B-07 & 08

SUMMARY OF FINDINGS

Youth who enter DJS' detention facilities often come into them with an array of issues: some may simply have lots of questions they need answered, some may be quite anxious about their detention status and some may suffer psychiatric problems that make them inappropriate for admission. An orderly and consistent intake process ensures youth who enter these facilities, such as the Hickey School, do so fully screened and if admitted, with the information they need in order to function successfully and know the rules of the facility.

Interviews and documentation showed a procedure, including medical and psychological screening, housing classification, property inventory, issuance of clothing and a handbook and the allowance of a phone call, is in place to move youth from intake into the general population in a structured and consistent way.

Orientation (the first two days of a youth's stay) occurs at Ford Hall. A handbook is given to Orientation youth to be sure they understand the rules of the facility; a check of ten youth base files found that all ten had an acknowledgement form signed by the youth stating they received a handbook. There are also groups and educational screenings that occur during Orientation.

Having a youth handbook is good practice, not only because it is required to be available by policy, but also because it is an excellent method for clarifying issues. Referencing the same handbook puts both the youth and staff "on the same page," often helping youth understand that staff are also required to follow certain rules regarding youth movement and bedtimes; it also lets the youth know what is and is not acceptable on the unit. Handbooks also help remind the boys of who key personnel are throughout the facility should they have a question.

Hickey's handbook is generally complete but has some deficiencies that need remedying:

First, the handbook should always be read from a youth's point of view. In other words, "If I were a kid, would I understand this?" The Behavior Management Plan (BMP) section is simply the memo to staff from the Superintendent on the BMP with the plan itself, including points and levels, stapled to the back of the handbook. This was meant for staff; youth need the BMP written out in simple terms they will understand and find easy to reference if they have a question. This "keep it simple" rule applies to all of the information in the handbook.

Second, there is some information not included in the handbook that should be. Examples include how to write a letter, when they are mailed and how to get stamps; the education program, that it is mandatory and what special services and programs are available; when the youth eat and where and how many times per day; when searches can occur and how they are done; and how to get special aids, TTY or a translator.

Third, "Child Advocate" should be changed to "Youth Advocate" throughout the handbook to reflect DJS' change in this Division's name. The Grievance/Appeal process itself is long but should certainly be included. Hickey may want to use a smaller font for just this section and print the handbook on both sides of the page in order to save paper. These simple steps would improve the handbook a great deal.

Upon entry, youth are to be screened using the FIRRST Health Care Screening. The intake staff person indicated properly that youth who screened positive on the FIRRST were not to be admitted and were sent back with the police for hospitalization or evaluation. A review of youth base files by the QI Team found that all youth had an updated copy of the FIRRST in their file.

Youth also are required to undergo MAYSI (mental health) and SASSI (substance abuse) screenings within two hours of admission. Again, the intake staff person was aware of this and specifically indicated these tests had to be completed within two hours and that she knew how to score the MAYSI and did so. She also indicated that the Behavioral Health clinicians from Glass Health were to be called if a youth scored high on the MAYSI and that the youth would immediately be placed on a 1-to-1 watch until a clinician advised otherwise. Very positively, the intake staff asks the youth to read the first line of the screening test to her to ensure he can read. If there are indications otherwise, she reads the screening test to him so he can complete it. This is an excellent

practice as many DJS youth have trouble reading; the practice should be duplicated at facilities statewide.

RECOMMENDATIONS

In order to reach Superior Performance status, the following is recommended:

- Ensure that all relevant information is included in the youth handbook including school, meals, special aid requests, mail call, etc. The Cheltenham handbook contains this information and may be a good resource to use for an example of a more complete handbook.
- Rewrite the BMP section in kid-friendly language. (Technical assistance from the QI Team available upon request.) Ensure youth understand the point/level system and who to ask if they have a question.

CLASSIFICATION — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that youth are classified and assigned housing according to standard criteria of risk, age, size, conduct, offense history, present legal charge and special needs..

SOURCES OF INFORMATION

- Interviews with Superintendent
- Interviews with Admissions/Intake Staff
- Review of Admissions Process Documentation
- Review of Intake Packet
- Interviews with Assistant Superintendent
- Observation of facility

REFERENCES

Maryland Standards for Juvenile Detention Facilities: DJS Classification Policy in editing stage; ACA 3-JDF-5A-02, 3-JTS-5A-01, 5B-01 through 04 and 5B-07 & 08

SUMMARY OF FINDINGS

Properly classifying and housing youth prevents young or vulnerable youth from being housed with or near older, more aggressive youth. Based on the layout of Hickey, youth can be classified into three different units based on age, aggressive history and medical and mental health status. (Note: there are four units at Hickey but Roosevelt Hall is closed for repair and should be re-opening this spring.) All youth are oriented to the facility on Ford Hall for the first three days in care. From there, they can be assigned to Clinton Hall, Mandela Hall, Roosevelt Hall once re-opened, or remain in the infirmary on Ford Hall. Currently, younger youth with less violent behaviors are typically placed on Mandela Hall, older and more aggressive youth are housed on Clinton Hall, and as mentioned, those youth with medical or mental health concerns are assigned to the infirmary on Ford Hall.

Interviews with the intake staff personnel revealed that the most recent updates to the Classification instrument had taken place three weeks prior to the QI review. The staff informed the QI team that the most recent classification/supervision tool was much easier to understand and score, however, a portion (number of prior serious incidents in custody) of the tool was not being scored due to the assessors having limited access to the ICAU database. Training had been provided, but access was not available. A call was made to Headquarters and the access issue was resolved the same week the QI Team was on-site. The intake staff person reported she now has the access she needs to fill in the instrument completely.

Nevertheless, twenty-five assessments were reviewed with 19 (76%) youth scoring within the low range. It is noteworthy to mention that those 19 youth who scored in the low range on the DJS Housing Classification instrument were cross reverenced with the incident reports that resulted in seclusions. None of the youth scoring in the low range were involved in incidents that resulted in seclusion.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Ensure that intake personnel include the score for the number of prior serious incidents in custody now that database access has been granted.
- Ensure the tool is also used to identify youth whose rooms should be closer to staff for increased level of supervision.
- Track the success of this effort to see if any changes in classification are benefiting the facility and its incident levels or locations. Consider discussion of this in the self-assessment meetings.

PENDING PLACEMENT RATING: Performance

STANDARD

Written policy, procedure and practice document that the facility has a list of youth pending placement, their days committed, and average length of stay and aggressively prioritizes these youth in order to assist the community case managers in placing them as quickly as possible in order to reduce time in detention. .

SOURCES OF INFORMATION

- Discussion with the Superintendent
- Facility Population/Pending Placement List
- Interviews with youth

REFERENCES

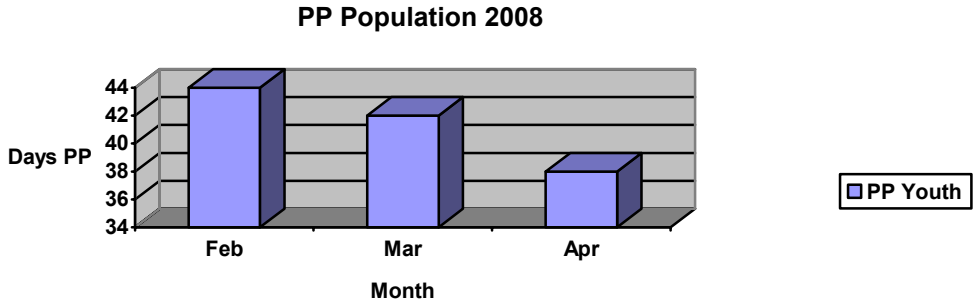
Maryland Standards for Juvenile Detention Facility, ACA 3-JDF-5H-01, 3DJF-3E; DJS Detention and Shelter Care Policy, SD-E2220-01-01

SUMMARY OF FINDINGS

Detention is limited to "those youth who pose a risk to public safety" and shelter is limited to "those youth who require temporary out of home placement for their personal safety, or because there is no parent, guardian, custodian or other responsible person available to provide twenty-four hour supervision and care for a youth and to guarantee a youth's return to a court when required."

On May 14, 2008, Hickey had a population of 61 youth and produced a list of 26 youth who were pending placement (PP). There were 10 youth PP over 60 days and 3 of those were PP over 100 days. The average length of stay (ALOS) for the pending placement youth on this day was 57 days.

The number of admissions during the review period rose; the total admissions for February 2008 were 55, while there were 74 in March, 71 in April and 49 thus far for the month of May. In spite of the rise in admission, the ALOS for PP youth has begun to decline, which is displayed in the chart below.



Discussions with the Superintendent and Assistant Superintendent revealed that the facility has "Stuck Kids" Committee meetings on a bi-weekly basis to expedite the placement process of pending placement youth. These meetings include personnel from field services, such as the Area Director, Case Management Specialists' and Resource Specialists'; there are headquarters as well as facility staff. DJS' Deputy Secretary of Operations spearheads this effort. Field Case Management Specialists' also are required to visit their youth on a regular basis and treatment team meetings also occur at the facility where the youth's placement, and expected release date, are discussed. The facility takes seriously its role in moving youth to placement as expeditiously as possible and recognizes the value of doing so.

RECOMMENDATIONS

In order to reach Superior Performance, it is recommended that the facility:

- Continue to place a priority on transitioning the pending placement population out of the facility through bi-weekly "Stuck Kids" meetings and other confinement review meetings.
- Encourage Case Managers to reach out to the prospective placements of the youth once they have been identified. In doing this, information can be shared by both parties and the facility's advocacy may expedite the placement process.

BEHAVIOR MANAGEMENT — RATING: Partial Performance

STANDARD
Written policy, procedure and practice document a behavior management system which provides a system of rewards, privileges and consequences to encourage youth to fulfill facility expectations and teach youth alternative pro-social behavior.

SOURCES OF INFORMATION

- Unit Log Books for all housing units
- Daily Point Sheets
- Unit Point Sheets
- Interviews with youth
- Interviews with staff
- Observations on housing units

REFERENCES
DJS Behavior Management Program Policy RF-10-07; Facility Behavior Management Program (BMP)

SUMMARY OF FINDINGS

Behavior Management Programs (BMPs) often are excellent ways to encourage youth to comply with facility rules. Good, well-thought out BMPs that include meaningful incentives can assist staff in steering difficult youth toward more positive behaviors. Hickey's BMP consists of five levels, beginning with the Orientation Level where youth are housed on Ford Hall. Once youth complete 72 hours of orientation they are assigned to Mandela or Clinton Hall where they are able to reach Levels I through IV.

Hickey provided documentation from 4/01/2008 to 5/13/2008. The dates reviewed included 10 days in April and 5 days in May. To supplement this six weeks' worth of documentation, staff and youth were interviewed and housing units were observed.

Interviews of staff and youth found that Ford Hall youth were being locked in their rooms for showers at approximately 6:30pm. This issue was remedies the day the QI Team was there (see Seclusion section for more detail). Some youth reported that they were all in bed by 8:00pm no matter what their level. This is in conflict with the level system which states that Level II bedtime is 8:30pm, Level III is 9:00pm and Level IV is 9:30pm. Some of these youth reported that only if they had a "good day" were they allowed to stay out of their room past 8:00pm.

The QI Team observed that most of the staff and youth at Hickey had a good understanding of the BMP. Youth did state that they receive all of the other rewards associated with the level system. All youth interviewed stated that they really enjoy going to the TMA building for commissary, Play station and movie night.

Overall, Mandela does an overall good job in documenting the youths' points with minor errors occurring. Ford and Clinton Hall showed numerous errors in documentation. Clinton Hall's point book was at times reviewed and corrected by a supervisor and a corrective action memo issued about the importance of accurate documentation which is a positive sign that the facility is aware of the issue and continues to work on correcting it. Listed below are some examples of errors in documentation:

Clinton Hall:

- On 5/11/08, the amount of point loss for profanity was 225 for 1 youth and 300 for another youth but the actual amount for such is 75 points.
- On 5/1/08 youth lost points for infractions but still made 100 points.
- On 4/22/08 all youth that had point reductions that were not listed on the back of the point sheet with an explanation as required.

Mandela Hall:

- On 5/11/08 descriptions for points deducted or unearned were not noted.
- On 5/1/08 and 4/6/08 addition errors were observed.
- On 4/22/08 there was a problem with transferring of points.

Ford Hall is in need of several adjustments due to the following findings:

- Not using the proper sheets (no back area for documentation);
- Not explaining why points weren't earned;
- Addition errors;
- Not following point reduction amounts;

RECOMMENDATIONS

In order to reach Performance, it is recommended that the facility:

- Use some of the examples above (or find new ones) to use in trainings with staff. Make a list of the staff who continue to have the same problem and document progressive discipline for those staff.
- Require unit managers to review point sheets daily. Require an initial on each sheet they review.
- Ask Shift Commanders to review point sheets daily as they walk through on their shifts. Require an initial on each sheet they review.
- Ask Case Managers to review point sheets and levels as an extra layer of oversight.
- Ensure correct forms are being used on Ford Hall.

STRUCTURED REHABILITATIVE PROGRAMMING	RATING: Performance

STANDARD

Written policy, procedure and practice document that youth receive planned, structured outdoor and indoor activities and regular rehabilitative programming, that teaches social skills.

SOURCES OF INFORMATION

- Review of 24-Hour Unit Schedules
- Interviews with youth
- Interviews with staff
- Interview with Superintendent

REFERENCES

DJS Recreational Activities Policy RF-08-07; ACA 3-JDF-5E-01-02-03-04

SUMMARY OF FINDINGS

Meaningful and structured programming is a vital part of any detention and treatment facility. Youth who are constantly engaged in social and other skill development are less likely to be involved in incidents and more likely to benefit from the skill-building this programming is intended to convey.

Based on interviews with staff along with an observation of the structured programming at Hickey, it appears that majority of the youth are engaged and interested in the activities being provided. At the time of the QI review Aggression Replacement Training (ART) was observed. Activity groups, journaling, and behavior management focus groups were also ongoing. Additionally, log books indicated that vendors, including Community Law in Action (CLIA) and Chess Club mentors were providing programming during scheduled days and times.

The unit schedules also indicated activities such as letter writing/book reading, arts & crafts, visits, team building, current events, morning focus group and in Ford Hall, student handbook review. In addition to all these activities, youth revealed in interviews that they are also receiving at least one hour of recreation each day. All of the youth indicated they had 1-2 hours of free time daily at the most, but far more on the weekends. Additional weekend programming would benefit the facility.

Structured programming was identified by 4 of the 6 staff interviewed as being one of the biggest improvements at the facility within the past six months.

RECOMMENDATIONS

In order to reach Superior Performance status in this area, it is recommended that the facility:

- Continue encouraging ongoing structured programming. Ensure vendors are clear about expectations and that they feel welcome and want to continue providing services.
- Add more weekend programming.

SELF ASSESSMENT	RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that the facility superintendent at least twice monthly meets with his or her management staff to assess the facility's status involving the use of seclusion, restraints, incident reporting numbers and procedures and other key area of facility operation in order to assess the facility's compliance with DJS norms and expectations.

SOURCES OF INFORMATION

- Interview with Superintendent
- Review of Incident Report Statistics

REFERENCES

None (DJS QI Policy in development)

SUMMARY OF FINDINGS

Self Assessment is a relatively new process for DJS facilities. Its function is to assess the critical indicators within each facility, including seclusion use, incident frequency, suicide watch numbers, and restraint use, as examples. Data to assess the effectiveness of key areas of facility operations is retrieved from DJS' Incident Database (e.g., frequency, time, location of restraints, seclusion, youth/youth assault and other critical incidents) and facility records (e.g., overtime, staffing patterns) The facility superintendent should lead a meeting at least every two weeks to ensure these crucial areas are examined.

Hickey's Superintendent holds Management meetings every Monday, Wednesday and Friday at 11am. These meetings cover a variety of issues. Though not formally Self Assessment meetings, they do discuss individual youth, incident rates, trends, seclusion use and youth on suicide watch as contemplated in the Self Assessment process. The Superintendent's secretary keeps minutes of these meetings. The Superintendent agreed to designate Mondays as the day where OIA database data could be more carefully scrutinized and assistance from the QI Team was offered to set this more formal process up; the goal being to make this a data-driven meeting that adds to everyone's knowledge of what is truly going on (and where) in the facility and to brainstorm ideas to resolve issues as they are happening.

The attendees of these current M/W/F meetings include himself, his Assistant Superintendents, and managers from Intake, Procurement, Behavioral Health, Case Management, Medical and Recreation. Education is invited, but more often than not, doesn't attend. The explanation given for the Principal not attending was that he could not leave the school unattended at this time. Since the Principal leaves the school unattended for other sorts of school-related business, it was recommended that he find a suitable substitute in the school while he is at the management meeting, or that he send an assistant principal or another high level school manager to attend in his place. Another

suggestion was to change the time to one that the administration and Education found acceptable. Education is a crucial component of facility operations as youth spend many of their waking hours in the school; the Principal or his designee should attend and participate.

RECOMMENDATIONS

In order to reach a Performance rating, it is recommended that the facility:

- Set up Mondays as the Self Assessment meeting day. Create a dated Self Assessment meeting agenda and include a sign in sheet of management staff attending and continue to keep minutes. Keep a file of each agenda with the data indicators discussed that week along with staff sign-in sheets.
- Document a summary of the weekly discussion to discuss in daily shift briefings to provide evidence that the data indicators are used in conversations with staff and to modify practices.
- Require Education to attend the Management meetings, at the very least every Monday at Self Assessment time. Adjust the meeting time or ask the Principal to send a designee.

BEHAVIORAL HEALTH

INTAKE, SCREENING & ASSESSMENT	RATING: Performance

STANDARD

Written policy, procedure, and practice require that all youth admitted to a facility will be screened by a qualified mental health professional in a timely manner using valid and reliable measures. All youth who screen positively for behavioral health issues will be referred for a full mental health assessment by a mental health professional. All youth who present at the facility with behavioral health issues that, as determined by professional mental health assessment, are beyond the scope of what the facility can safely treat, will be transferred to a setting that can more appropriately meet the youth's needs.

SOURCES OF INFORMATION

- Youth medical files
- Interview with the Superintendent
- Interviews with youth
- Interview with
- Unit daily schedules

REFERENCES

DJS Suicide Policy (HC-1-07)

SUMMARY OF FINDINGS

Many youth who enter DJS' detention facilities present with mental health and substance abuse needs that have been in the past undiagnosed and untreated. These behavioral problems, if left untreated, can lead to further substance abuse, delinquency, and violence. Because of that fact, it is vitally important that the opportunity to treat detained youth with mental health and substance abuse problems does not pass without positive action steps being taken to improve the lives of these young people in our care. Part of these action steps includes timely and appropriate screening of youth at intake.

Based on the census on the day of evaluation, 20% of charts were reviewed. Of those charts, ten were active and two youth were recently discharged. All of the charts reviewed contained the FIRRST initial medical screen and the MAYSI mental health screening. Ninety-two percent contained the SASSI substance abuse screen. In the medical file, the FIRRSTs were marked with the time of administration. Since the MAYSI and SASSI are required to be administered within two hours of admission, intake staff should also mark the time of administration. The intake staff person did know the policy on this and reported she does administer both screening tools within two hours.

The intake staff person also noted that when she receives a youth's past mental health evaluations, she places them in the youth's base file. A copy should also be placed in the medical file so that the clinicians have ready access to it. The intake staff told the QI Team that making an extra copy for medical would not be difficult and that she would begin doing so right away.

Suicide assessments were conducted on youth who gave evidence of potential harm to self or others. Since youth may not be suicidal at intake but may become suicidal while detained, processes must be in place to ensure they are assessed. When these instances were reviewed, it was found that youth were referred to Behavioral Health professionals. In all of the charts reviewed, the youth was seen by a mental health professional or a referral to a mental health professional had been made.

Behavioral health conducts intake assessments with youth as well. Youth are seen by the psychiatrist as needed. When the youth demonstrates behavioral health problems beyond the scope of the facility they are referred out for treatment to an appropriate placement in the area, usually Sheppard Pratt or Spring Grove Hospital center.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Time stamp the screening tools with the time of admission and the time of administration for the MAYSI, SASSI, and FIRRST in every case to demonstrate timely administration.
- Make an extra copy of any past mental health evaluations that come into Intake and place a copy in the youth' medical file.

INFORMED CONSENT — RATING: Partial Performance

STANDARD

Written policy, procedure, and practice requires that youth, and when appropriate, their guardian, are informed of the risks, benefits, and side effects of medication and the potential consequences of stopping medication abruptly. Youth are also notified that their conversations with clinicians, though confidential, may be shared with DJS and the Court if requested.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Informed consent is a process of communication between a youth and clinician that results in the youth's authorization or agreement to undergo specific interventions. Informed consent means that the youth was given sufficient information to make a decision regarding his or her mental health care. In turn, the youth should have an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of intervention.

Of the youth on medication, 82% of their charts had a signed consent form giving the facility permission to distribute the prescribed medication to that youth. However, these consent forms were not informed consents because they did not contain information regarding the side effects, risks, benefits, and purpose of the medications. Informed consents that describe the medication in depth were found in 18% of the charts.

The behavioral health provider has an excellent set of informed consent forms. When reviewing the medical charts, base charts, and behavioral health back up charts, copies of these forms signed by the youth and his guardian could not be located. These forms are important because they explain to the youth and their guardian why they are taking a medication, what benefits it will provide, and what potential side-effects may occur. The behavioral health treatment provider states that they will begin to retain a back up copy of these signed forms. These signed informed consent forms should be placed in the youth's medical chart.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Complete the informed consent for each medication that a youth is prescribed, ensure that the youth signs it, and file it in the medical chart.

PSYCHOTROPIC MEDICATION MANAGEMENT	RATING: Performance

STANDARD

Written policy, procedure, and practice require that psychotropic medications are prescribed, distributed, and monitored properly and safely.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

When the decision is reached that a youth should take medication, active monitoring by all caretakers is essential. Youth should be watched and questioned for side effects because many young people simply do not volunteer information. They should also be monitored to see that they are actually taking the medication and taking the proper dosage on the correct schedule.

Thirty-seven percent of youth were treated with psychotropic medications at the time of this review. An average of 41% of these youth were being treated with Seroquel. All youth who were prescribed psychotropic medication had been seen by the psychiatrist and had a psychiatric diagnosis recorded in the chart.

Medical staff observe the youth as they ingest their medications. Youth redistributing their medications to others on the unit does not appear to be an issue at this time, though it has occurred at Hickey in the past. There were many refusals to take medication documented in the chart. For one youth, there were 63 refusals for treatment listed in the chart, many of them being refusal to take psychotropic medications. Other refusal rates varied from one to 26. One youth never commenced medication therapy due to refusals.

In order to more effectively and efficiently treat youth, it is important that we get an idea as to why they are refusing to take their medication. The reason a youth refuses a psychiatric medication should be noted on the refusal sheet. These reasons can be reviewed and analyzed to better understand the needs of the individual youth.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Document each youth's reasons for refusal of psychiatric medications and review youth individually. Look for patterns and frequency of refusal and review these in weekly behavioral health and/or medical staff meetings.
- Once it is understood why a youth is refusing, brainstorm ideas to solve the underlying problem. Getting the family involved often can be helpful.

BEHAVIORAL HEALTH SERVICES & TREATMENT DELIVERY	RATING: Performance

STANDARD

Written policy, procedure, and practice require that appropriate mental health and substance abuse treatment and emergency services are provided by qualified mental health professionals and substance abuse counselors, that it is integrated with psychiatric services when applicable, and that it is appropriate for the adolescent population. Crisis intervention services should be available in acute incidents. All admitted youth should receive alcohol and drug abuse prevention /education counseling. Family involvement should be highly encouraged. Behavioral health issues should be considered when providing safe housing for youth at the facility.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

The juvenile justice system is focusing extraordinary efforts on addressing concerns about the mental health needs of delinquent youth. Recent advances in understanding mental disorders of adolescence have been joined by new neuroscience information about brain development in adolescence, as well as behavioral science findings documenting socio-emotional differences between adolescents and adults that offer different explanations for the illegal acts of youth. Youth can have behavioral health disorders that interfere with the way they think, feel, and act. Behavioral health influences the ways youth look at themselves, their lives, and others in their lives. These advances are confirming that adolescents are better served by a different response to their offenses. For some youth, contact with the juvenile justice system is often their first and only chance to get help with their mental health and substance abuse issues.

In reviewing 12 charts, 11 were found to possess documentation of mental health treatment. In the twelfth chart, a referral for mental health services had been made. Psychiatric treatment was documented in the same 11 charts. Mental health treatment included groups and individual and crisis counseling. Group therapy was documented in 75% of the charts reviewed. Importantly, the other 25% of the charts provided reasons

why the youth could not attend group (i.e. too violent, broken jaw, etc.) Consistently, all youth who were able to accept individual therapy received it.

Youth who were assessed to be mentally ill beyond the treatment capacity of the facility were referred out for appropriate services. In six charts, youth were assessed to need a higher level of psychiatric care and were transferred to either Spring Grove Hospital Center or Sheppard Pratt, primarily. Prior to these transfers, the youth received crisis services at the facility; crisis services are available on demand at Hickey and the clinical staff always have a 24 hour, 7 day per week on call clinician available for youth with acute needs.

Youth who remain detained at the facility are housed according to their needs. Behavioral health issues are considered along with ability to adapt to the milieu, size, aggressiveness, and age.

Of charts reviewed, 83% of youth received substance abuse treatment and a referral had been made for another 8%. Substance abuse services are offered in the form of education groups and individual counseling. Feedback from youth and behavioral health staff noted that increasing the availability of substance abuse process groups would be highly beneficial. Youth would benefit from talking about what it is like for them personally once they leave detention and return home and to discuss their substance abuse triggers.

Documentation of family therapy was only found in one chart. Interviews with behavioral health professionals indicate that family therapy is occurring often at Hickey. Behavioral health reports that 14 relatives are involved in family therapy with 12 youth. Between 12/2007 and 4/1/2008, 59 family conferences were conducted. The progress notes from these family sessions should be placed in the behavioral health section of the medical record as evidence that the family is involved in the youth's treatment.

Because the Behavioral Health unit keeps their own files, this information and others is not always shared with all of the persons having access to the youth's entire history in his medical file. The mental health information also is not noted on the Master Problem List in the medical file. All of the youth's needs and problems, from basic allergies to needed dental care to mental health diagnoses and medication listings, should be on the Master Problem List and updated regularly.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Implement substance abuse process groups within the therapeutic schedule in order to address youth's feelings.
- Include family therapy notes in the medical record's behavioral health section.
- Document all mental health diagnoses and medications on the Master Problem List in the youth's medical file.

TREATMENT PLANNING — RATING: Partial Performance

STANDARD

Written policy, procedure, and practice require that all youth in the facility in need of behavioral health treatment will have a signed collaborative treatment plan that addresses, at a minimum, a behavior management plan, and mental health and substance abuse issues as indicated. Behavioral health records will provide evidence of collaboration and communication among team members working with a youth, while maintaining the youth's confidentiality.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

A collaborative treatment plan, following a thorough assessment, identifies the youth's strengths and needs while assisting the clinician in focusing on the youth's most severe problems and barriers to recovery. The treatment plan, like the assessment, becomes multidimensional. Reassessment of youth needs and responses to treatment strategies allows the individualized treatment plan to become an evolving document, changing as youth issues are resolved, when outcomes are met, or when treatment strategies do not achieve the desired effect. Perhaps most importantly, youth can be more effective partners in their own treatment when the problems being addressed and the desired outcomes are clearly articulated.

Of the charts reviewed, 75% contained an initial treatment plan and evidence of treatment team meetings. The treatment plans addressed behavior management, mental health, substance abuse, and school performance. The plans briefly, but not fully, touched on transition planning.

The treatment plans located in the charts are not collaborative. The plans were signed by the behavioral health professional and the youth exclusively. However, the treatment plan meeting that was conducted during this review proved to be more collaborative that the documentation would suggest. It is important that everyone involved in the treatment planning process sign the treatment plan and that these signatures are placed in the chart. Representatives from community case management are not always present at

these meetings; they should be so that continuity of care can be enhanced. It may be helpful to copy the community case managers' supervisors with the time and date of treatment team meetings in order to promote increased attendance.

The treatment plan format used at Hickey does not lend itself to including updates and progress toward stated goals on the form itself. The treatment plan format should be edited so that it provides space for progress notes, updates, and team signatures. Treatment plans should undergo timely updates and be filed in the behavioral health section of the medical records.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Implement a collaborative treatment planning process similar to the model used at Cheltenham Youth Facility where the treatment plan is signed by all interested parties including the youth, pertinent facility staff, behavioral health staff, school personnel, community case worker, and family. The plan should allow for progress updates and team signatures to be included.
- Document the attendance of treatment team members to the treatment team meetings, including community case workers.
- Copy the case workers' supervisors on meeting invitations and notices and consider sending emails to them to follow-up when workers do not respond or attend.
- File treatment plans in the behavioral health section of the medical chart.

TRANSITION PLANNING — RATING: Partial Performance

STANDARD

Written policy, procedure, and practice requires that staff facilitate appropriate transition plans for youth leaving the facility. Youth, and their guardian when appropriate, should receive information on behavioral health resources, a prescription for medication continuation, and assistance in contacting behavioral health aftercare services to schedule follow up appointments.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Transition planning is a specialized process for detained youth that occurs both in the facility and in the community. Transition planning and the aftercare process refers to those activities and tasks that: 1) prepare juvenile offenders for entry into their communities or into a treatment facility; 2) establish the necessary arrangements and linkages with the full range of public and private sector organizations and individuals that can assist the youth with his behavioral health needs; and 3) ensure the delivery of prescribed services and medications to the youth upon exiting the facility.

The concept of transition planning is briefly addressed in the intake assessment when the youth first arrives. It is also touched upon in the treatment team meeting. The charts that were reviewed provided no other transition planning documentation.

Staff interviews revealed that a transition plan is completed at the time of discharge and put into the chart post discharge. Closed charts were reviewed but only one partially completed transition plan was found. In one chart, transition plans were noted but not solidified.

Transition plans should be comprehensive and documented in the chart. They should be initiated close to the time the youth is admitted since discharge could occur at any time. Youth should have in place as many resources as are reasonably possible upon exiting detention to increase their chances for success if released into the community. The Transition form should be filled out completely before a youth is allowed to be released

and a copy sent with him. Another copy mailed to the parent would ensure they are aware that the facility has set up appointments, referrals, or a prescription at a home neighborhood clinic or pharmacy. Without more documented proof of the Transition Forms and processes, it seems youth may be released from Hickey too often without knowledge of referrals and services available to him at home.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Implement a comprehensive, collaborative transition plan that is initiated close to the time of admission and is as inclusive as reasonably possible.
- Require intake staff to fill out a Transition Form upon admission and enact a procedure to ensure that document is updated regularly by all disciplines. Write an FOP that gives staff step-by-step direction on what the expectations are for planning for a young man's departure from Hickey.
- Do not release a youth without ensuring his Transition Form goes with him and is filled out with as much information as is reasonably possible. Ensure a copy is mailed to his home address as well and that instructions to the parent or guardian for following up on appointments or prescriptions are included.

SUICIDE PREVENTION

DOCUMENTATION OF YOUTH ON SUICIDE WATCH	RATING: Performance

STANDARD

Written policy, procedure, and practice require that all newly arrived youth, youth in seclusion, and youth on suicide precautions are sufficiently supervised. Suicide precaution documentation must include the times youth are placed on and removed from precautions, the current level of precautions, the youth's housing location, the conditions of the precautions, and the time and active circumstances of the youth's behavior.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Suicide Observation Forms Feb-May 2008
- Suicide Logs Feb-May 2008
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

Every administrative, direct care, medical and clinical staff and every other person working with youth in the custody of the Department of Juvenile Services (DJS) are responsible for trying to protect them from suicidal or harmful actions by and to themselves in all facilities operated by the agency. In order to assure that this is done completely and satisfactorily, suicide watch precautions must be taken and always according to DJS policy.

During the period under review, nine youth were on suicide watch and the documentation for all nine youth was reviewed. Of these nine youth, four were being treated with psychotropic medications and five were not. The Suicide Observation Form documents each youth's actions during the day and must be updated at staggered intervals six times per hour. On all suicide observation sheets, the youth's suicide watch level was indicated. Individual Suicide Watch Tracking Logs were completed for all nine youth and they were completed at appropriate and timely intervals. This documentation was not kept in the chart (medical file) but instead is kept in a separate binder, divided by individual youth names.

Consistently with all nine youth, the times indicated on the Suicide Watch Sheets did not always indicate AM or PM. This is helpful in management audits of forms and in quickly reviewing the sheets if that youth had a recent problem that needs further investigation. There were several instances noted where times were written over other times. It is important that this not occur because it raises questions about the authenticity of the checks.

In the observation sections of the sheets, locations were sometimes documented (i.e. school, free-time, safe and secure) but not actions (i.e. writing in notebook, talking with peer.) The youth's actions must be documented in the observation column. The reason: when a young man is on suicide watch, it is not as important where he physically is at that moment, what is vital is to know what he is doing. If a youth is "crying" or "staring straight ahead" for an hour, this indicates he may need immediate clinical intervention. If the youth is "joking with friends" and "playing football," this may indicate he can be stepped down a level and is feeling better. Staff must not only be told to do something ("document this way") but also why that documenting is so important. Line staff are often a vital source of information about a youth's adjustment and should be reminded about how important that role is.

Other segments of the documentation raised concerns but were not patterns of any kind. Examples include: on 3/16/08, a youth is observed for three straight hours as "in room sitting". On 4/3/08 one set of checks was illegible and on 4/20/08, for approximately 1 ½ hours the checks were not signed. Though these were one-time occurrences, the accuracy of all suicide checks must be a priority due to the gravity of the potential consequences of missing a check.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Review all Suicide Watch Sheets for errors at the end of each shift.
- Ensure all staff are aware of their duties while a youth is on watch; they should always document what the youth is doing rather than where he is and never write over a check. Cross it out with one line if there is an error then re-write and initial.
- Remind staff not only how to do something (document properly and completely on Suicide Observation Forms) but also why it is so crucial that they do so accurately.

ENVIRONMENTAL HAZARDS — RATING: Partial Performance

STANDARD

Written policy, procedure, and practice require that all housing for youth at heightened risk of self-harm is free of identifiable hazards that would allow the youth to commit suicide or other acts of self harm. In case of emergency, all direct care staff at the facility should have immediate access to appropriate equipment to intervene in an attempted suicide. Chemicals and other hazards are properly stored and locked.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

A thorough tour of Hickey provided evidence of good overall control to eliminate environmental hazards. Rooms were contraband free. Most chemicals were behind locked doors.

DJS Policy requires all direct care staff to carry a cut-down tool in case of an attempted suicide. In interviews with six direct care staff, four noted they do not carry a cut-down tool and two said they do only "sometimes." Some staff indicated that they used to carry them all of the time but now they are often locked in the unit manager's office. In an emergency, this is not safe. These tools should be ordered immediately and all staff issued one and reminded to carry it with them at all times.

While the reviewer's observation confirmed that the Unit Manager and any staff with 1:1 supervision responsibility for youth on Suicide Watch Level III were in possession of a cut down tool, all direct care staff need to have immediate access to the tools. When the tools arrive, staff should be trained on the proper way to use them.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Provide cut down tools and training on how to use them to all direct care staff.

CLINICAL CARE FOR SUICIDAL YOUTH	RATING: Performance

STANDARD

Written policy, procedure, and practice require that timely suicide risk assessments, using reliable assessment instruments, are conducted at the facility for all youth exhibiting behavior that may indicate suicidal ideations to determine whether a youth should be placed on suicide precautions or whether the youth's level of suicide precautions should be changed. Youth at a facility who exhibit suicidal ideations or attempts should receive timely, appropriate, and professional mental health services. Youth should not be restricted from programs and services more than safety and security needs dictate. All pertinent staff should review all completed suicides and suicide attempts at the facility for policy and training implications.

SOURCES OF INFORMATION

- Youth medical files
- Interview with Superintendent
- Interviews with youth
- Interviews with staff
- Observation at facility

REFERENCES

DJS Suicide Policy (HC-1-07), ACA 3-JDF-3E-04, 4C-27 & 28, 4C-35, 5A-02, 3-JTS-4C-22, 4C-24, DJS Incident Reporting Policy (MGMT-2-01); COMAR 14.31.06.13.J

SUMMARY OF FINDINGS

As stated previously, nine youth were placed on suicide watch during the period under review. For all nine youth, a thorough suicide assessment was completed by a behavioral health professional and a suicide risk level was assigned and documented. Suicide risk levels were reevaluated on a timely basis and suicidal youth were seen by behavioral health staff no less than daily. Three of the nine youth made an attempt to inflict self harm and incident reports were filed. No evidence suggested that suicidal youth were unnecessarily restricted from regular programming which is commendable.

Suicides and serious attempts may be rare, but they do happen at facilities across the country. It is good practice to have a Facility Operating Procedure (FOP) that spells out the course of action post-incident so that each and every occurrence is processed in an appropriate and expedient manner. No current FOP could be produced at Hickey to guide the review of all suicides and serious suicide attempts that may occur there.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the facility:

- Write (or produce, if current) a Facility Operating Procedure (FOP) that delineates the procedure for reviews of serious suicide attempts and completed suicides.
- Inform pertinent staff that they are delineated in the FOP as the core processing group should a serious suicide attempt or completion occur.

EDUCATION

SCHOOL ENTRY	RATING: Performance

STANDARD

Written policy, procedure and practice document timely enrollment of all students into the educational program. The school will receive a daily roster of students. The receipt of student records should occur in a timely manner.

SOURCES OF INFORMATION

- Interview with record staff
- Review of 16 student folders (9 general education, 7 special education)
- Review of Daily Population Report
- Review of Night Sheets
- Review of the Committed/Detained Student List

REFERENCES

- COMAR 13A.08.07.01: Education-Student in State Supervised Care-Transfer of Educational Records
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

The Hickey School employs two full-time registrars who request all of the records from the students' previous schools and educational placements. A review of records indicated that the first request for records was usually completed in three days following school enrollment. The second requests were also done in a timely manner. The school also employs a full-time Diagnostic/Prescreening Specialist who assesses the students upon entry to the school. Thirteen of the sixteen records reviewed were received within five days of the first request.

As found during the last QI review, the school receives a Committed/Detained Student List, an alphabetical list of students in the facility listing their units and ASSIST numbers, however, the lists provided to the school are two days old. When the QI Reviewer requested rosters, the Night Sheet and the Daily Population Report for the current date were promptly provided by the facility. The Night Sheet included the students' dates of birth, jurisdictions, community case mangers and the students' dates of admission. The Daily Population Report listed the facility's admissions and releases and transfers. This information would be valuable to the school as it gives complete and up-to-date information; the school would then be aware of the students on the campus daily (and know even more about them) so that the registrars would be able to request records in an even more timely manner.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Ensure that the school is provided with the Night Sheet and Daily Population Report on a daily basis.

CURRICULUM & INSTRUCTION — RATING: Partial Performance

STANDARD

Facility schools will ensure that they provide instruction appropriate to the varied needs and abilities of the students enrolled. They should operate on a standard schedule, provide students with a consistent school day, provide instruction appropriate to individual students' strengths and needs, provide pre-GED & GED instruction as appropriate, provide extracurricular and enrichment activities & events, integrate computer assisted instruction in the curriculum and provide library services. Facility schools will also ensure that students in alternate settings (i.e. infirmary, seclusion and orientation) are given access to assignments and instruction comparable to other students in the facility.

SOURCES OF INFORMATION

- Review of School schedules
- Observation of transitions to and from class
- Classroom observations
- Interview of teaching staff
- Student interviews
- Administrator interview

REFERENCES

- MSDE Guidelines
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

As during the last QI review, a variety of instruction methods were demonstrated by teachers and educational staff. Staff generally reported that they had the materials that they needed on a daily basis. The school has a functioning library and the students reported that they are allowed to take books with them. The school offers an Advanced Studies Program in which students who demonstrate the aptitude are given instruction toward their GED certificates. It should be noted that during the review, two students from the facility sat for their GED certificates on the Hickey Campus.

Education is provided for two hours per day to the students housed in the infirmary by one of the special education teachers. The DJS SOP for Special Education Service Delivery in Secure Detention Facilities indicates that the services should be provided to similarly situated special education students for four hours per day. The reviewer observed the educational class in the infirmary setting. The reviewer arrived to the space designated for education prior to the scheduled class time only to find that the space was being used as a holding area for students to see the dentist. The teacher arrived and was told that he would have to be provided with another area for his class. After almost thirty minutes the teacher and students were then directed to a room that was very small and

had poor lighting. The facilities' assistant superintendent indicated that within a matter of weeks, a new infirmary area would be opening that included a designated education area to alleviate the problem. Until that space is available, another appropriate place should be designated. (Note: the new infirmary area opened on June 4, 2008.) It was also unclear why some of the students in the infirmary were not receiving services in the school. Many of the students were ambulatory and were capable of participating in the regular school day, yet they remained in the infirmary. Other students that are housed on the infirmary go to the school building every day.

The movement of youth to school in the morning and afternoon was observed. The students arrived in school in the morning on time, but were consistently late following the lunch time. Students were observed to be up to 20 minutes late for the class period following the lunch break.

RECOMMENDATIONS

In order to reach Performance status in this area, it is recommended that the facility:

- Develop a system to get students to school on time after lunch.
- Ensure that students housed on the infirmary who are medically cleared to attend school attend classes in the regular school building.
- Designate an appropriate and dedicated space for students in the infirmary for educational services. When the new infirmary opens and is functioning, ensure there is follow-up with infirmary youth and teachers that space is available to them.
- Provide instruction in the infirmary in accordance with The DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SCHOOL STAFFING & PROFESSIONAL DEVELOPMENT	RATING: Performance

STANDARD

The Facility School will maintain a sufficient number of certified staff to provide appropriate education to all students, including related services providers. The school should provide meaningful staff development opportunities to teachers and support staff to enhance their ability to effectively educate youth in detention settings.

SOURCES OF INFORMATION

- Roster of teaching staff
- Administrator interview
- Teacher and IA interviews

REFERENCES

- No Child Left Behind Act of 2001, (NCLB), P.L. 107-110
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

The Hickey School staff consists of: one principal, one teacher supervisor (who also teaches the Advanced Studies Program), one Science teacher, one English teacher, one Math teacher, one Occupational Skills Training (OST) teacher, four special education teachers, one Transition Specialist, one Guidance Counselor, one Diagnostic/Prescreening Specialist, five instructional assistance, two registrars and one secretary. Related Services, such as counseling and speech language services, are provided by contractors. The counselor is full-time and is housed in the school building. The school has vacancies for a computer teacher and a media specialist. For the current average daily population on campus, this represents an adequate number of teaching staff.

Teachers reported that they are provided staff development activities throughout the year and the school also provided a schedule of those activities.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Continue to hire needed staff including a computer teacher and media specialist.

SCREENING & IDENTIFICATION	RATING: Performance

STANDARD

Qualified professionals shall provide prompt and adequate screening of facility youth for special education needs, including identifying youth who are receiving special education in their home school districts and those eligible to receive special education services who have not been so identified in the past.

SOURCES OF INFORMATION

- Interviews with records and teaching staff
- Review of student folders

REFERENCES

- Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1400-1490
- COMAR 13A.08.07.01: Education-Student in State Supervised Care-Transfer of Educational Records
- DJS SOP for Special Education Service Delivery in Secure Detention Facilities

SUMMARY OF FINDINGS

The Child Find process is tied closely to the record retrieval process. The students are assessed as a means of identifying any "red flags" in academic areas. Also, all the students are interviewed to determine previous educational placements and if the student has been previously identified as needing special education services.

A review of student folders indicated that this was done in a timely manner and that the information was used to appropriately place the students in the classes that they needed. Most staff members were able to articulate a referral process for students who did not currently receive special education services, but whose behavior and/or academic needs warranted discussion. All staff should be able to do so.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Ensure that all staff members are aware of the procedures for referring a student who is demonstrating behavioral and/or educational concerns.
- Ensure that students who have not previously received special education services and with "red flags" affecting their current educational performance are referred for screening to determine their eligibility for special education.

PARENT, GUARDIAN & SURROGATE INVOLVEMENT	RATING: Superior Performance

STANDARD

Written documents show that parents, guardians or surrogate parents are notified of and invited to participate in evaluations, eligibility determination, Individualized Education Programs (IEPs) development and team meetings, and decisions regarding provisions of special education services.

SOURCES OF INFORMATION

- Review of IEP documentation
- Interviews with record retrieval and teaching staff
- Review of student folders
- Review special education files

REFERENCES

- Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1400-1490

SUMMARY OF FINDINGS

Parent, guardian or surrogate involvement is important in IEP meetings and other discussions about each youth's educational needs and progress. Review of special education files found copies of invitation letters and telephone logs (indicating attempts to reach the parent/guardian so that they could be involved in the development of IEPs.) The files also included receipts of certified letters to the parents. There were at least three attempts to contact parents documented in all of the files reviewed. The letters indicated the purpose of the meeting and indicated that procedural rights were provided to the parents.

The Hickey School solicits parent surrogates from the trained surrogates list from the students' home school districts.

RECOMMENDATIONS

The facility has achieved Superior Performance for this standard

INDIVIDUALIZED EDUCATION PROGRAMS — RATING: Performance

STANDARD

Written policy, procedure and practice provide that Individualized Education Programs are completed according to federal, State and departmental guidelines.

SOURCES OF INFORMATION

- Review of special education student files

REFERENCES

- Individuals with Disabilities Education Act (IDEA), 20 U.S.C. 1400-1490

SUMMARY OF FINDINGS

A review of records indicated that the IEP teams were properly constituted with the required participants, including related service providers. The IEPs indicated a continuum of services from inclusion to self-contained classes. Meeting notes seemed to demonstrate that the team was considering the best options for the student. Related services logs in the folders were up to date. The log entries were consistent in time and frequency and appeared to correspond to the services identified on the students' IEPs.

There was one concern involving student IEPs which was the timeliness of the meetings that were scheduled and held. Meetings were consistently scheduled for over a month after students arrived at the facility. With the dynamic nature of detention, many students' meetings would not occur because they would have been released or moved from the facility prior to the meeting dates. Once the facility school identifies a youth as needing services, a meeting should be set up as soon as possible. Since many of our youth go on to either other DJS facilities, DJS placements, or their home schools after leaving Hickey, if the IEP meeting has been held, those notes and that youth's file can be transferred and services begun immediately. By waiting, the school delays the required services that youth may have already needed for some time for yet another month or likely more. In the case of school age young men, especially those with a poor education history, any delay that can be avoided should be.

RECOMMENDATIONS

In order to reach Superior-Performance in this area it is recommended that the facility:

- Ensure that IEP meetings are scheduled promptly to facilitate appropriate delivery of services. Track the meeting dates and average length of time between admission and meeting date to gauge if progress is being made.

CAREER TECHNOLOGY & EXPLORATION PROGRAMS	RATING: Performance

STANDARD
The facility will provide students opportunities to explore career interests and to develop skills useful in obtaining employment.

SOURCES OF INFORMATION
- Review of school schedule
- Interview with students

REFERENCES
MSDE Guidelines

SUMMARY OF FINDINGS

Young people with limited education backgrounds or those with a high hands-on skill aptitude often are more reachable and teachable when vocational options are offered to them. Learning basic skills such as measuring, drawing a basic plan, cutting and building with different materials and tool identification and use are skills that may at some point lead them to a trade that is an employment option and a key to future job opportunities.

The Hickey School offers the Occupational Skill Training (OST) class. Students are able to develop skills in building trades. Students reported that they enjoy the class and that they are developing skills in that they find useful. Though this is an excellent class, the school should explore even more options for technical and vocational education.

RECOMMENDATIONS

In order to reach Superior Performance in this area it is recommended that the facility:

- Identify multiple options for career technology and exploration

SECTION 504 PLANS — RATING: Superior Performance

STANDARD

The facility will ensure that accommodation and services are provided according to each student's Section 504 plan. The facility will also ensure that students' Section 504 plans are reviewed and revised as needed.

SOURCES OF INFORMATION

- Interviews with education staff
- Review of Student files

REFERENCES

- Section 504 of the Rehabilitation Act of 1973 (Section 504), 29 U.S.C. 794
- DJS Section 504 Guidelines

SUMMARY OF FINDINGS

During the QI Review, there were two students at The Hickey School with Section 504 plans. Both of the students' files indicated that the students' plan was reviewed and/or revised during meetings at school.

The parents were invited to participate in the development of both plans. Staff members at The Hickey School indicated that they received copies of the plans. Each staff member that was asked could explain what a 504 plan was; they were able to do so and they knew the students who had 504 plans.

RECOMMENDATIONS

The facility has reached Superior Performance for this standard.

STUDENT SUPERVISION — RATING: Performance

STANDARD

The facility will ensure that staffing is appropriate to supervise students in the educational setting, as well as during transitions to and from the school setting.

SOURCES OF INFORMATION

- Classroom observations
- Observation of transitions
- Staff interviews.
- Interview of facility administrators

REFERENCES

- Maryland Standards for Juvenile Detention Facilities

SUMMARY OF FINDINGS

A week prior to the QI review, the federal education monitor indicated concerns surrounding the supervision of students in the school setting. In particular, students were observed to move around the school with little supervision and there were few visible direct care staff members in all parts of the building to monitor the youth. The self-contained special education classroom and the OST shop had no direct care staff assigned.

By the first day of the QI review, there were four new staff posts in the building. According to the facility's Assistant Superintendent, a staff member was permanently assigned to the self-contained classroom and the OST class. He also indicated that new post orders were being written for the school. In addition, there were now two supervisors assigned to the school building. The education staff reported that there was a marked improvement in the halls and the classrooms from the previous week. The reviewer noted that there was clearly less movement of students in the halls during class time and that the school was quiet. Though it is positive to see that the facility acted quickly to alleviate the problem, the administration must remain vigilant to ensure this new structure is a permanent change.

RECOMMENDATIONS

In order to reach Superior Performance, it is recommended that:

- Ensure the Supervisors and new posts continue to resolve the issue of students being in hallways unsupervised. Stop in on occasion unannounced to check on the new structure. Involve the teachers and principal and get their feedback on the continued improvement.

SCHOOL ENVIRONMENT & CLIMATE	RATING: Partial Performance

STANDARD
The facility will ensure that the school setting is a safe environment conducive to learning and that staff are supported in their jobs.

SOURCES OF INFORMATION
- School observation
- Interviews of Educational staff
- Interviews of Direct Dare staff
- Interviews of students

REFERENCES
N/A

SUMMARY OF FINDINGS

Due to the hallway supervision issue discussed in the Student Supervision section of this report, educational staff indicated previously that the lack of supervision of the students made them feel less safe. Only with continued evaluation of the new structure will this to be deemed to have been resolved. It seems to be off to a solid start.

Educational and direct care staff both expressed the concern that there is a breakdown in the communication between the MSDE and DJS on the needs surrounding education. Education staff members indicate that they are not included in decisions that are made that impact the school and the students. Conversely, DJS staff members indicate that MSDE has been forthcoming with the concerns that need to be shared but that they do not participate in planning meetings that are frequently held on the campus. The lack of communication has created a tension that is evident in the school and may slow or halt the progress that the school has had in improving the educational program. One way to alleviate this problem would be for the principal to attend the Superintendent's management meetings at least weekly as discussed in the Self-Assessment section of this report. This is an excellent opportunity for Education to have the ear of the administration and to team up to resolve small problems before they become difficult to manage.

RECOMMENDATIONS

In order to reach Performance in this area it is recommended that the facility:

- The facility and school should review its system of communication; the principal should attend meetings at least weekly with senior administrators at Hickey.
- The facility and school should continue team building training for educational and facility staff.

MEDICAL CARE

HEALTH CARE INQUIRY REGARDING INJURY	**RATING: Performance**

STANDARD:
Written policy, procedure, and practice ensures that all youth are seen by medical staff after any incident in which they are involved, regardless of whether there is an injury, shortly after the incident occurs.

SOURCES OF INFORMATION:
Facility Incident Reports Jan.15-Apr.15 2008
Interview with Superintendent
Interviews with youth
Observation at facility

REFERENCES:
DJS Incident Reporting policy (MGMT-03-07); Photographing of Injuries policy (RF-11-05); Reporting & Investigating Child Abuse Policy (MGMT-1-00)

SUMMARY OF FINDINGS

Prompt medical care after an incident protects each youth's health and safety. Even when no injury seems to be present, a medical check and opinion is necessary to ensure that the young person is not injured or does not need emergency care. Hickey has 24 hour nursing care. Because of this, youth involved in an incident can and should see the nurse immediately following any incident, and certainly within 1-2 hours unless there are other extenuating circumstances.

In a review of 12 incidences of youth-on-youth assault, group disturbance and suicide gesture or ideation, 11 required a medical check. In 10 of the 11, the youth saw the nurse as required; the other, a suicide-related remark by a youth did not require a nurses' visit, but he was immediately seen by a behavioral health clinician. (Interestingly, in the other suicide ideation/gesture incident, it may have been the case that the staff and /or behavioral health clinician did not know or think the youth needed to go to the nurse because there was no injury to him. But in that case, the youth should have gone to the nurse for a welfare check, especially since he eventually had to be handcuffed. By policy, the youth must see the nurse following a mechanical restraint.)

The Nursing Report of Youth Injuries form, or body sheet, in the 11 incidents reviewed involved a total of 31 youth. Staff indicated to the QI Team in interviews that youth had to be seen by Medical immediately following an incident. Of those 31 youth reviewed, 30 saw the nurse as required and nearly all (97 %) of them saw the nurse within 1-2 hours after the incident. This is an excellent record of compliance with prompt medical care,

even with the current Med Satellite building being so far from the units and school. When the new Medical unit opens in Clinton Hall, the expectation is that this compliance with policy will likely be even easier for the facility.

The body sheets were complete in all cases. The Injury Severity Ratings (ISRs) were appropriate for the injury sustained and the youth's statements and nurse's notes were included as well as the time and date of the visit. Photographs were present in every case, and there were usually multiple ones to review.

RECOMMENDATIONS

In order to reach Superior Performance status, the facility must:

- Ensure all youth involved in any type of mechanical restraint are seen by the nurse promptly, even if no injury is suspected.

HEALTH ASSESSMENTS — RATING: Partial Performance

STANDARD

Written policy, procedure and practice document that adequate health assessments are completed on all youth within 72 hours of admission.

SOURCES OF INFORMATION

- Interviews with medical staff
- Interviews with youth
- Nursing logs
- Medical file review

REFERENCES

ACA 1-SJD-4C-18-19-20 DJS Special Needs Treatment Plans Health Care Procedure (2007); ACA 1-SJD-4C-18-19-20

SUMMARY OF FINDINGS

Complete health assessments upon admission are crucial for quality care and identification of chronic care issues in DJS youth. Upon a review of eight youth health record files, all eight had the seven page nursing assessment completed at the time of admission. All admission physicals were completed within 72 hours of admission.

The admission physicals lacked documentation of vital signs in three of the eight records reviewed. Vital signs must be dated the day they were taken if different from the day the physical is dated. Admission labs were completed on six of the eight youth; only four of the six had completed lab results filed .A vision screen was available in six of the eight charts reviewed.

All eight had documentation of a PPD being administered. Seven of the eight that had Tb skin tests completed had the results appropriately documented. But in a review of the PPD log book from January thru May 2008 found the documentation to be lacking. There were 201 PPDs administered and of that number 47 entries had no documentation noting the results. There was also no reason listed why the PPD had not been read.

On a positive note, allergies were documented consistently and notification by Health Status Alert was completed to the respective disciplines in the facility.

The immunization tracking and referral forms continue to not be consistently completed on all youth health record files. . This form, when utilized, would track immunization records requested, received, reviewed and immunizations ordered. It would also track follow-up referrals, appointments and completion of the appointments especially dental exams and follow-ups. Due to the recidivism rate of the youth at Hickey, it is imperative that this be consistently utilized.

Documentation was present in seven of the eight youth health record files that immunization records had been requested and in six of the eight these immunization records had been received, reviewed by the MD/NP and immunizations ordered. The immunization records are being requested and in a review of the MD orders written, seventeen youth had immunization orders, but no vaccines had been administered. Twelve of the seventeen youth should have already been administered their immunizations, the five remaining had orders less than ten days old.

There is a lack of consistent documentation to indicate that attempts that are being made to obtain consents for the immunizations ordered by way of phone calls to parents and letters requesting written consent. This also includes immunization orders that are covered under the minor consent law that are not being administered, such as Hepatitis B.

The Master Problem Lists were being utilized. Seven of the eight youth had Master Problem Lists with most of the information required. There were some with youth problems missing and some that lacked consistent completed interventions with resolution dates. Mental Health continues to lack documentation of mental health issues on the Master Problem Lists.

Asthma Treatment Plans are being completed. The new procedure for the use of the Asthma Assessment Tool and the Nursing Progress Note used for the Assessment of Need for Rescue Inhaler are in placed and being utilized.

In addition, the Sick Call log is being utilized as directed The Growth/BMI Charts were present in seven of the eight Youth Health Record files; of those seven, the heights and weights were plotted but the BMIs were not present. The 30 Day Assessments are being completed.

RECOMMENDATIONS

In order to reach Performance status in this area it is recommended that the health care unit at the facility:

- Complete the vision screen for all youth that are seen upon admission for a complete nursing assessment. If there is a reason why it was not completed as part of the admission nursing assessment, document that fact and add specific follow-up information.
- Date the vital signs the day they were taken if different from the day the physical is dated.
- Ensure a standardized procedure or checklist is followed so that all youth have PPDs administered and read with proper documentation.
- Ensure that immunization records are requested from IMMUNET, parents, schools and physicians as required. The MD/NP is required to review, date and sign the record once received and prescribe any immunizations needed. Ensure the nurse obtains the proper consents and administers the vaccines as prescribed.

- See that documentation of the immunization requests, date received, date reviewed and date administered are completed on the Tracking and Referral form in the youth health record file.
- All physician-ordered immunizations must be completed as prescribed immediately.
- Document on the Immunization Tracking and Referral form any initial or follow-up referrals, appointments and completion of the appointments.
- Complete Master Problem Lists with any and all medical and mental health-related information about the youth so that, at a glance, the youth's overall health needs are known to the nurses, physicians and mental health staff.
- Growth /BMI Charts must be in every chart with proper documentation.
- The *Asthma Assessment Tool* and the Nursing Progress Note for the *Assessment of Need for Rescue Inhaler* are in place and must continue to be utilized. Training for all the nurses was completed by DJS Health Services Division on May 7, 2008.

MEDICATION ADMINISTRATION — RATING: Performance

STANDARD
Written policy, procedure and practice document that medications are given as prescribed.

SOURCES OF INFORMATION
- Interviews with medical staff
- Interviews with youth
- Nursing logs – MARs
- Medical file review

REFERENCES
DJS Pharmaceutical Services policy (HC-02-07); ACA 1-SJD-4C-16-17

SUMMARY OF FINDINGS

Proper medication administration is an important responsibility we have to our youth. DJS youth may require pain management, psychotropic, and other medications to allow them to function comfortably in normal activities of daily living while in detention.

In a review of eight youth health record files, it was found that all youth had been properly prescribed medications by the MD/NP. Upon review of the MARs (Medication Administration Records) medications were being properly administered. In one of the eight charts reviewed there was one order for a medication that lacked documentation from the MD of the reason the youth was being prescribed that particular medication.

Sometimes, youth who may refuse, are sent to court or are released for other reasons might not receive a dose of their prescribed medication. Documentation is present to support the missed doses of medication.

The CDS (controlled drug substance) shift inventory is in place with proper documentation and the sharps count inventory also is in place with proper documentation.

RECOMMENDATIONS

In order to reach Superior Performance, it is recommended that the health care unit at the facility:

- If incomplete documentation from the MD presents, return to the MD to document the reason why a medication was prescribed.

DENTAL CARE — RATING: Performance

STANDARD
Written policy, procedure and practice document all youth receive timely and adequate dental care.

SOURCES OF INFORMATION
- Interviews with medical staff
- Interviews with youth
- Nursing logs
- Medical file review

REFERENCES
ACA 1-SJD-4C-22

SUMMARY OF FINDINGS

Youth who are admitted to DJS often come to us with dental needs that have been neglected prior to their admission. Youth present with common problems such as a lack of good dental hygiene, cavities, missing teeth, and a poor understanding of why taking care of their teeth is important.

Dental examinations are completed with screenings, prophylaxis and treatment by a dentist at Hickey. Dental pain is managed according to a nursing protocol for dental pain (and collaborating physicians' orders) to keep the youth comfortable until prior to and after treatment is received as necessary.

In review of the Sick Call log management of dental complaints was appropriate.
There was not documentation on the tracking and referral form in the Youth Health Record file of previous, pending, and completed dental appointments which needs to be implemented as previously stated in this report. (Health Assessment)

Documentation from the dentist is acceptable but lacks the youths name and date of service consistently on the actual dental treatment/exam form. The documentation is completed on the attached referral form and the two are stapled together. If the papers were to come apart there would be no way of knowing to whom the dental record belonged.

RECOMMENDATIONS

In order to reach Superior Performance status in this area, it is recommended that the facility:

- Document on the tracking and referral form all dental appointments made and completed. Ensure this listing remains up-to-date.
- Document youth's name, date of birth and date of service on each dental treatment/exam form.

MEDICAL RECORDS RETRIEVAL — RATING: Performance

STANDARD
Written policy, procedure and practice document that efforts are made upon a youth's admission to obtain prior medical records.

SOURCES OF INFORMATION
- Interviews with medical staff
- Interviews with youth
- Nursing logs
- Medical file review

REFERENCES
ACA 1-SJD-4C-18-19-20

SUMMARY OF FINDINGS

Past information about each youth is crucial when deciding on a diagnosis, medication choice, or medical or behavioral management intervention.

Youth detained at Hickey who do have a history of having previous health records on file at that facility have those previous files pulled and in use when they return. Upon a general review the process for the request of records from other providers, that process is intact and functional.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Notify DJS' Nurse Manager if after follow-up the facility is unable to obtain the records from another DJS facility.

SPECIAL NEEDS YOUTH — RATING: Performance

STANDARD

Written policy, procedure and practice document that youth with special needs are screened as such upon admission within 72 hours, have a special needs treatment plan put into place, identifying the problem/need, goals, intervention, the youth's progress evaluation and review date.

SOURCES OF INFORMATION

- Interviews with medical staff
- Interviews with youth
- Nursing logs
- Medical file review

REFERENCES

DJS Health Care Procedure—Special Needs Treatment Plans (2007)

SUMMARY OF FINDINGS

DJS frequently houses youth with special needs, including asthma, diabetes, skin integrity, traumas and mental health-related issues, in our facilities. Special Needs Treatment Plans are a way of tracking that youth's problem, identifying interventions, and tracking their success. Upon a review of MARs, logs and in a general review of youth who required a Special Needs Treatment Plan, it was found that they were being completed. There were instances where the Plan showed a need for some improvement however, in the detail of the listing of interventions and resolutions. All youth housed in the Infirmary should continue to have Special Needs Treatment Plans actively in place. Operational Procedure for the youth in the Infirmary states that the youth are to be checked by a nurse every two hours with documentation in the Youth Health Record file. Upon review, this was being completed.

RECOMMENDATIONS

In order to reach Superior Performance status in this area it is recommended that the facility:

- Continue to review all youth files and complete Special Needs Treatment Plans on any youth with an acute health diagnosis or a special need; address with more detail in every case the interventions used and ultimate resolutions.

SPECIAL NOTE:

The new Health Center at Hickey should be open and functional on June 4, 2008. The new physical plant will greatly lend itself to an increase in the efficiency of the delivery of health care to the youth served. Nursing services will be under one roof and so there will no longer be a need to staff two to three areas on campus at one time. This should decrease the number of nursing hours having to be provided by the contracted nursing agency and will mean more continuity of care by the same nursing staff on a daily basis.